MedStar Medical Group at Old Emmorton Road
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Bel Air, Maryland 21015
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Name_____Date of Birth_____
Last First MI Preferred
Address_____
Street Number Road Apt Number
_____
City State Zip
Home Phone(____)_____Cell Phone(____)_____Work Phone(____)_____

WHICH PROVIDER ARE YOU SEEING? **Dr. Isckarus,MD Dr. Louderback-Smith,MD, Natalie Cadden, CRNP Alison Mueller, P.A.-C, Lynette Khanna, CRNP**

APPOINTMENT DATE AND TIME: _____

PAST MEDICAL HISTORY: (Have you ever had any of the following? Please check appropriate box)

Do you have or have you ever had?	YES	NO	Do you have or have you ever had?	YES	NO
Chest Pain			Indigestion / Heartburn		
Angina			Abdominal Pain		
Heart Attack			Appendicitis		
Congestive Heart Failure			Hepatitis		
High Blood Pressure			Irritable Bowel Syndrome		
Blood Clots / Thrombosis			Constipation / Diarrhea		
Anemia			Colitis		
Stroke / CVA			Cirrhosis		
Heart Murmur			Hemorrhoids		
High Cholesterol			Ulcer		
Seizures / Epilepsy			Gallbladder Disease / Gallstones		
Parkinson's Disease			Pancreatitis		
Headaches			Renal Failure		
Dizziness / Fainting			Kidney Stones		
Memory Loss			Bladder Infection		
Numbness/ Tingling Sensation			Prostate Problems		
Ringing in Ears			Kidney Infection		
Hearing Loss			Herpes		
Depression			Chlamydia		
Anxiety			Aids / H.I.V.		
Unusual / Increased Stress			Syphilis		
Glaucoma			Gonorrhea		
Sinusitis			Genital Warts		
Sore Throat			Thyroid Disease		
Cataract			Diabetes		
Allergic Rhinitis			Lyme Disease		
Asthma			Lupus		
Emphysema / COPD / Chronic Bronchitis			Gout		
Pneumonia			Skin Rashes		
Shortness of Breath			Arthritis		
Tuberculosis			Osteoporosis		
Cancer / Type:			Herniated Disc / Disc Disease		

Patient's Name_____Date of Birth_____

PERSONAL HABITS/HISTORY:

TOBACCO USE:
Do you currently or have you ever used tobacco? **YES**_____ **NO**_____ If **YES**, please answer the following:
TYPE: Cigarette___ Pipe____ Cigar____ Chew____ How much per day_____ When did you start? _____
Have you tried to quit? ____ When did you quit? _____

RECREATIONAL USE:
Do you use any recreational drugs? **YES**_____ **NO**_____ If **YES**, please answer the following:
Type of drug: _____ Amount consumed in a day:_____
How often do you use? _____ Have you ever tried to quit?_____
Have you ever felt the need to quit? **YES**_____ **NO**_____

ALCOHOL USE:
Do you drink alcohol? **YES**_____ **NO**_____ If **YES**, please answer the following:
Type of alcoholic beverage: _____ Amount consumed in a day:_____
How often do you drink? _____ Have you ever tried to quit?_____
Have you ever felt the need to cut down or quit drinking? **YES**_____ **NO**_____

CAFFEINE USE:
Do you use caffeine? **YES**_____ **NO**_____ If **YES**, please answer the following:
Type of caffeine: (i.e. colas, coffee, tease, chocolate) _____
Amount consumed in a day of each:_____

SLEEP:
Do you have any difficulty falling asleep? **YES**_____ **NO**_____
Do you use any sleep aids? **YES**_____ **NO**_____ If **YES**, what do you use? _____
Do you wake up feeling rested? **YES**_____ **NO**_____ Do you snore? **YES**_____ **NO**_____
Do you have daytime drowsiness? **YES**_____ **NO**_____ On average, how many hours do you sleep? _____

EXERCISE:
Do you exercise regularly? **YES**_____ **NO**_____ If **YES**, what type? _____
How often per week?_____ Duration of exercise:_____minutes

DIET:
Are you on any type of special diet? **YES**_____ **NO**_____ If **YES**, please indicate below:
_____

VACCINATION HISTORY:

When was you last influenza vaccination (flu shot)?_____
When was your last pneumococcal vaccination (pneumonia shot)? _____
When was your last tetanus booster? _____
If you have had the Hepatitis Vaccine, when was it? _____
If you have had the Varicella (chicken pox) Vaccine, when was it? _____
If you have had the Zostavax (shingles) Vaccine, when was it? _____
If born after 1957, did you have the MMR Vaccine? _____

Patient's Name_____Date of Birth_____

FAMILY HISTORY: Please indicate if your blood relatives have or have had any of the following diseases:

	Husband	Wife	Mother	Father	Mother's Mother	Mother's Father	Father's Mother	Father's Father	Siblings
Heart Disease/ High Cholesterol									
Lung Disease									
Diabetes									
Kidney Disease									
Thyroid Disease									
Hypertension									
Bleeding Disorder									
Arthritis									
Stroke/CVA									
Mental Illness: Depression Schizophrenia Suicide(or attempt)									
Cancer (indicate type)									
Alcoholism									
Obesity									
Age of death (if applicable)									

CHILDHOOD ILLNESSES:

	YES	NO		YES	NO		YES	NO
Measles			Chicken Pox					
Mumps			Scarlet Fever			Rheumatic Fever		
Rubella			Croup			Polio		

HOSPITALIZATIONS: (Please list each of your hospitalizations/surgical procedures, date and reason)

DATE AND PLACE	REASON

Patient's Name_____Date of Birth_____

*Are you currently serving or have you ever served in the military? **YES**_____ **NO**_____
If **YES**, which branch, where and when did you serve? _____
*Do you wear a seat belt? **YES**_____ **NO**_____
*Do you wear protective sports gear when appropriate (i.e. helmets)? **YES**_____ **NO**_____ **N/A** _____
*If you have firearms in your home, do you keep them safe, locked, out of the reach of children?
_____ **No firearms in home** _____ **Yes, I keep them safe** _____ **No, not safely kept**
*Do you have smoke detectors? **YES**_____ **NO**_____
*Do you have a carbon monoxide detector? **YES**_____ **NO**_____
*Have you had a colonoscopy? **YES**____ **NO**____ if **YES,** when? _____ by whom? _____
*Have you seen a dentist in the last 6 months? **YES**_____ **NO**_____
*Are you missing any teeth? **YES**_____ **NO**_____
*Do you have dentures, plates, or false teeth? **YES**_____ **NO**_____ If **YES**, indicate which:_____
*When was your last eye exam? _____
*Do you wear glasses or contacts? **YES**_____ **NO**_____
*Have you ever had a blood transfusion? **YES**_____ **NO**_____ If **YES**, when? _____
*Have you ever engaged in ANY activity that could expose you to HIV infection? **YES**_____ **NO**_____
*If you are sexually active, do you ALWAYS practice safe sex? **YES**_____ **NO**_____ **married / NA** _____
*If you are sexually active, do you currently have multiple sex partners? **YES**_____ **NO**_____
*Have you ever been the victim of sexual abuse? **YES**_____ **NO**_____
*Who lives in your household? _____

FOR WOMEN ONLY:

MENSTRUAL HISTORY:

Age at onset of menstruation: _____ Frequency: _____ days Duration: _____ days
Last menstrual period: _____ Irregularities? YES_____NO_____ Explain:_____
Cramps? YES_____ NO_____ Medication for cramps? _____

OBSTETRICAL HISTORY:

Are you pregnant? YES_____NO_____ Are you planning a pregnancy? YES_____NO_____
Total pregnancies:_____ Full Term:_____ Preterm:_____ Miscarragies/Abortions:_____
Did you have any complications with your pregnancies? YES_____ NO_____ If YES, please explain:
_____
Have you ever taken estrogen or birth control pills? YES_____ NO_____
Do you have any unusual vaginal discharge or itching? YES_____ NO_____
Do you have pain or lumps in your breasts? YES_____ NO_____
Do you perform regular breast exams? YES_____ NO_____
When was you last gynecological exam? _____
Who is your gynecologist? _____
When was your last mammogram? _____
Method of contraception, if any: _____

FOR MEN ONLY:

Have you ever had prostate trouble? YES_____ NO_____ If YES, please explain:
_____
Have you ever been told you have a low testosterone level? YES_____ NO_____
Do you perform regular testicular exams? YES_____ NO_____
When was your last rectal exam? _____
When was your last PSA test? _____
Do you have a urologist? YES_____ NO_____ If YES, please supply name_____

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MEDICATIONS: (Please list the names of any medications, dosages, and the reasons for taking them. Be certain to include all over the counter, herbal, eye, skin, or other medications)

MEDICATION	DOSAGE (MG / FREQUENCY)	REASON FOR TAKING

ARE YOU ALLERGIC TO ANY MEDICATIONS OR HAVE ANY MEDICATIONS MADE YOU SICK OR WORSE IN ANY WAY? YES_____ NO_____ IF YES, PLEASE EXPLAIN BELOW:

MEDICATION	REACTION

ARE YOU ALLERGIC TO ANYTHING ELSE? YES_____ NO_____ IF YES, PLEASE EXPLAIN BELOW:

_____

_____

_____

_____