MedStar Greater Annapolis Medical Group
2003 Medical Parkway, Suite 100
Annapolis, MD 21401
Phone: (410) 573-1110

Name____ Date of Birth __________
Last First MI Preferred

PAST MEDICAL DIAGNOIS

Adult Illnesses. (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			Colitis		
Anemia			Cirrhosis		
CVA / Stroke			Hemorrhoids		
Heart Murmur			Ulcer		
High Cholesterol			Gallbladder Disease		
Seizure / Epilepsy			Pancreatitis		
Parkinson's Disease			Renal Failure		
Headaches			Kidney Stones		
Dizziness / Fainting			Bladder Infection		
Memory Loss			Constipation		
Numbness/ Tingling Sensation			Prostate Problems		
Ringing in Ears			Kidney Infection		
Depression			Herpes		
Anxiety			Chlamydia		
Glaucoma			Aids / H.I.V.		
Sinusitis			Syphilis		
Sore Throat			Gonorrhea		
Cataract			Genital Warts		
Allergic Rhinitis			Thyroid Disease		
			Diabetes		
Asthma			Lyme Disease		
Emphysema / COPD			Lupus		
Chronic Bronchitis			Gout		
Pneumonia			Skin Rashes		
Shortness of Breath			Arthritis		
Tuberculosis			Osteoporosis		
Cancer / Type:			Herniated Disc / Disc Disease		

Patient's Name____Date of Birth______________

HOSPITALIZATIONS

Please list the reason for hospitalizations with the approximate date and the place

Reason	Date & Place
1.	
2.	
3.	
4.	

PERSONAL HABITS

TOBACCO USE:

Do you use tobacco? YES______NO_If yes, please answer the following questions:

Pipe______Cigarette_______Cigar_______Chew________Number of packs per day? ____

Number of tobacco use?_____Number of times attempted to stop? _________

Have you stopped? YES____NO_____Are you interested in stopped? YES_____NO______

RECREATIONAL USE:

Do you use any recreational drug? YES_____NO_____If yes, please answer the following question:

Type of drug:__________________________Amount consumed in a day______________________

How often do you use?____

Have you ever felt the need to quit? YES___NO_______

ALCOHOL USE:

Do you use alcohol in any form (beer, wine, liquor)? YES____NO____

Type of alcohol beverage:____________________ Amount consumed in a day_______

How often do you drink?____

Have you ever felt the need to cut down on your drinking? YES ____NO_____

CAFFEINE USE:

Do you use caffeine (i.e. colas, coffee, teas, chocolate)? YES ____NO____ If yes, please indicate: ______________

DIETARY:

Are you on any special diet? YES___NO___If yes, please indicate:______________________

Do you use nutritional supplement? YES___NO___If yes what type?

Please outline a typical daily food intake:

BREAKFAST		SNACK	
SNACK		DINNER	
LUNCH		SNACK	

Patient Name: ___________________________________ Date of Birth ______________________

SLEEP:
Do you have difficulty falling asleep? YES____NO_____DO you have early AM awakening? YES NO___
How many hours of sleep do you receive per night- average?__
Do you use anything to help you fall asleep? YES___NO___If yes, what do you use? ________________
Do you wake up rested in the morning? YES___NO___ Do you snore? YES____NO _____
Do you have daytime drowsiness? YES___NO___

EXERCISE:
Do you receive regular aerobic exercise? YES___NO___If yes, what type? _____________________
How often per week?________________________________Duration each time:____________minutes

MILITARY SERVICE:
Are you currently in the military, or have you been in the Military? YES___NO___If yes, when and when did you serve (deployments)?

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____

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	Sibling's
Heart Disease High Cholesterol									
Lung Disease									
Diabetes									
Kidney Disease									
Thyroid Disease									
Hypertension									
Bleeding Disorder									
Arthritis									
CVA/ Stroke									
Mental Illness Depression Schizophrenia Suicide									
Cancer (give type)									
Alcoholism									
Obesity									
Age of death (if applicable)	___	___	___	___	___	___	___	___	___

Patient Name: _____________________________________ Date of Birth _______________________

ALLERGIES

Please list allergies to food, meds, and other items

	ITEM ALLERGIC TO	REACTION
Food:		
Medication:		
I.V. Contrast: Yes No (circle one)		
Other:		

CHILDHOOD ILLNESSES

Please check appropriate box if immunized against (received vaccination or had illness).

	YES	NO		YES	NO
Scarlet Fever			Chicken Pox		
Mumps			Measles		
Rubella			Rheumatic Fever		
Asthma			Croup		
Pneumonia					

FOR WOMEN:

MENSTRUAL HISTORY:

Age of onset _______ Frequency_______Days

Last menstrual period ________ Irregularities: YES_____NO______If yes, please explain:___________

____

Cramps: YES_______NO_______If yes, please circle: mild moderate severe

Medication for cramps:____

OBSTETRICAL HISTORY:

Are you pregnant? YES_____NO ______ Are you planning a pregnancy? YES____NO _____

Total pregnancies: ______ Full term _____ Premature ______ Miscarriages______

If any miscarriages please indicate: Spontaneous___________________Induced __________________

First pregnancy: (Month/year) ____________ Last pregnancy: (Month/year)____________

Complication of pregnancy:(Please check appropriate complication, if any.)

High blood pressure_______ Kidney infection_______ Cesarean______ Hemorrhage______

Excessive weight gain _____ Babies over 9lbs.______ Anemia______ Toxemia _______

Contraception, if any: ______

Concerns:____

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