MedStar Physician Partners

Metropolitan Medical Associates – Honeygo Professional Center
5009 Honeygo Center Drive, Suite 216
Perry Hall, MD 21128
Telephone 410-256-5858 Fax 410-529-2431

JEFFREY COOL, M.D. **ASHA POTTI, M.D.**
LISA SPEIGHT, M.D. **INNA KATS, M.D.**

PERSONAL HEALTH SUMMARY

NAME:_____ **DOB:**_____

APPOINTMENT DATE:_____ **DOCTOR**_____

What do you consider to be your main health problems?

1._____

2._____

3._____

PAST MEDICAL HISTORY

Have you ever had any of the following? (check appropriate lines):

Scarlet Fever	_____	High blood pressure	_____
Rheumatic Fever	_____	Diabetes	_____
Childhood diseases	_____	Heart disease	_____
Tuberculosis	_____	AIDS	_____
Tuberculosis	_____	HIV	_____
Venereal diseases	_____	Hepatitis (yellow jaundice)	_____
Pneumonia	_____	Severe motor vehicle accident	_____

Please supply details:_____

_____

_____

Please list each of your hospitalizations, date, and reason:

DATE(Month/Year)	**HOSPITAL/PHYSICIANS**	**REASON**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any surgeries not listed above:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list the names of any medications you take, dosages, and the reason for taking them. Make certain to include all over the counter, herbal, eye, skin, or other medications.

MEDICATIONS	**DOSAGE (mg/frequency)**	**REASON FOR TAKING**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ARE YOU ALLERGIC TO ANY MEDICATIONS OR HAVE ANY MEDICATIONS MADE YOU SICK OR WORSE IN ANY WAY?

Please list names of medications and reactions:

_____

_____

Have you ever had a transfusion? Please list how much blood you received, the date(s), and any reactions:

_____

FAMILY HISTORY

Please list the names, ages, and current health status of your parents, siblings, and children:

NAME	RELATION	AGE	ALIVE/DEAD	HEALTH PROBLEMS
_____	_____	____	_____	_____
_____	_____	____	_____	_____
_____	_____	____	_____	_____
_____	_____	____	_____	_____
_____	_____	____	_____	_____
_____	_____	____	_____	_____

Do any diseases run in your family? Please list:_____

_____

SOCIAL HISTORY

Where were you born and raised?_____

How much schooling have you had?_____

What has been your main occupation and are you currently employed?_____

_____

What has been your most recent job?_____

Marital Status:_____ Religion:_____

Do you or did you ever smoke cigarettes, cigars, a pipe, or other form of tobacco?

Please supply details (when you started, quit, how much do/did you smoke): _____

_____

Do you drink alcohol? Please supply details (how often, how much, when did you start, do you drink in the morning? Have you tried to cut back?)_____

_____

Do you use any other drugs besides those listed above? Have you ever used intravenous (IV) drugs?

Please supply details: _____

_____

Are you under any unusual stress at home or work? If so please explain:_____

_____

Who lives in your household?_____

Do you have any close friends or family near your home? Please supply their names and telephone numbers if available:

_____

_____

_____

What do you do in your free time?_____

REVIEW OF SYMPTOMS

How would you describe your health? _____Good _____Fair _____Poor
Are you sick a lot of the time? _____Yes _____No
Do you tire easily? _____Yes _____No
Do you sleep poorly? _____Yes _____No
Have you lost weight in the past year without trying? _____Yes _____No How much?_____
Have you lost your appetite lately? _____Yes _____No
How tall are you now?_____ What was your height at your tallest?_____
Have you had:

Anemia (tired blood) _____Yes _____No		Kidney trouble	_____Yes _____No
Unexplained fevers	_____Yes _____No	Liver trouble	_____ Yes _____No
Peptic ulcer	_____Yes _____No	Stroke	_____Yes _____No
Hemorrhoids (piles)	_____Yes _____No	Nervous breakdown	_____Yes _____No
Recent ear infection	_____Yes _____No	Recent runny nose	_____Yes _____No
Is your hearing poor	_____Yes _____No		

Do you have constant ringing noises in your ears? _____Yes _____No
Are you having trouble with your vision or sight? _____Yes _____No
Do you wear glasses? _____Yes _____No
Do you have pains in your eyes? _____Yes _____No
Does your nose run or stop up a lot? _____Yes _____No
Do you often have nose bleeds? _____Yes _____No
Do you have sinus trouble? _____Yes ____No
Are you missing many teeth? _____Yes _____No
Do you wear plates or false teeth? _____Yes _____No
Are you troubled by sore or bleeding gums? _____Yes _____No
Do you have frequent sore throats? _____Yes _____No
Have you ever had any serious skin trouble? _____Yes _____No
Do you have pain or tightness in your chest when you are working or exercising? _____Yes _____No
Do you get shortness of breath that wakes you up? _____Yes _____No
Does your heart race or skip? _____Yes _____No
Do you have swelling in your feet? _____Yes _____No
Do you sleep on two pillows because of your breathing? _____Yes _____No
Do you get cramps in your legs while walking? _____Yes _____No
Do you usually have a cough? _____Yes _____No

Have you ever coughed up or spit up blood?	_____Yes	_____No
Are you short of breath when climbing stairs or up a hill?	_____Yes	_____No
Have you had asthma (wheezing) attacks?	_____Yes	_____No
Do you have trouble swallowing?	_____Yes	_____No
Do you have stomach pains more than once a week?	_____Yes	_____No
Are you troubled by vomiting or nausea?	_____Yes	_____No
Do you often feel bloated or full of gas?	_____Yes	_____No
Are you troubled by diarrhea?	_____Yes	_____No
Are you troubled by constipation?	_____Yes	_____No
Have your bowel habits changed recently?	_____Yes	_____No
Have you ever had a bowel movement that was black, like tar, or bloody?	_____Yes	_____No
Do you have trouble urinating (passing your water)?	_____Yes	____No
Does you have burning when you urinate?	_____Yes	_____No
Have you ever passed kidney stones?	_____Yes	_____No
Do you urinate more than two times a night?	_____Yes	_____No
Have you ever noticed a swelling or lump in your neck, armpits, or groin?	_____Yes	_____No
Do you have a goiter?	_____Yes	_____No
Do you feel colder or warmer than most people?	_____Yes	_____No
Do you often get leg cramps at night?	_____Yes	_____No
Are your joints often painful or swollen?	_____Yes	_____No
Have you ever had any serious trouble with your back?	_____Yes	_____No
Have you broken any bones (including collapsed vertebrae?), which one(s)?	_____Yes	_____No
Have you ever been told you have thin, brittle bones?	_____Yes	_____No
Do you suffer from severe headaches?	_____Yes	_____No
Do you often have spells of dizziness?	_____Yes	_____No
Have you ever fainted (passed out)?	_____Yes	_____No
Do you have numbness or tingling in any part of your body?	_____Yes	_____No
Do you have weakness in any part of your body?	_____Yes	_____No
Have you ever been knocked out?	_____Yes	_____No
Have you ever noticed any shaking of your body?	_____Yes	_____No
Have you ever had a seizure, fit, spell or convulsion (epilepsy)?	_____Yes	_____No
Have you been dpressed or down, most of the day, nearly every day, for two weeks?	_____Yes	_____No
Have you been less interested in most things, or less able to enjoy the things you used to enjoy?	_____Yes	_____No
Do you have difficulty concentrating or making decisions almost every day?	_____Yes	_____No
Do you get upset or irritated easily?	_____Yes	_____No
Do frightening thoughts keep coming to your mind?	_____Yes	_____No
Have you ever thought of yourself as a worthless person?	_____Yes	_____No
Have you felt that life is entirely hopeless?	_____Yes	_____No
Do you frequently wish you were dead and your troubles were over?	_____Yes	_____No
Were you ever in a hospital for your nerves?	_____Yes	_____No
Are there any sexual problems you want to discuss?	_____Yes	_____No

MEN ONLY

Have you ever had prostate trouble? _____Yes _____No
Have you ever been told you have a low testosterone level? _____Yes _____No
Have you taken testosterone shots? _____Yes _____No
When was your last rectal examination? _____

WOMEN ONLY

How old were you when you first started having menstrual periods? _____
How many times have you been pregnant? _____
Did you have any problems with your pregnancies? _____Yes ____No
If yes, please describe_____
How many miscarriages or abortions have you had?_____
Were there any times besides your pregnancies when your menstrual periods were not regular?
_____
Have you had bleeding between periods or after "change of life"? _____Yes _____No
Have you ever taken estrogen or birth control pills? _____Yes _____No
Do you have pain or lumps in your breasts? _____Yes _____No
Do you think you have unusual vaginal discharge or itching? _____Yes _____No
When was your last gynecological exam? _____
Who is your gynecologist? _____
When was your last mammogram? _____

Please supply details for any positive answers in the above sections:

_____

_____

PREVENTIVE MEDICINE

When was your last influenza vaccination? _____
When was your last pneumococcal vaccination? _____
When was your last tetanus booster? _____
If you had the Hepatitis B vaccine, when was it? _____
When was your Varicella vaccination? _____
If older than 18 and born after 1957, did you have an MMR? _____
Do you wear seat belts routinely? _____
Have you seen your dentist routinely? _____