MedStar Physician Partners

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MEDICAL/SOCIAL HISTORY FORM

PLEASE complete this form to the best of your knowledge. For first health assessment, fill out both sides.

Name	Date of Birth	Place of Birth	Occupation	Primary Care Physician
	/ /			

Date of Visit	Highest Level of School	Religious Preference (not required)	Organ Donor?	Who Referred You?

Medical History: List serious illnesses, injuries, operations, and other hospitalizations and indicate year these occurred.

PROBLEM	YEAR	PROBLEM	YEAR

LIST MEDICINES YOU TAKE NOW (INCLUDING VITAMINS, BIRTH CONTROL PILLS, OVER-THE-COUNTER DRUGS)

MEDICINE AND DOSE (IF KNOWN)	MEDICINE AND DOSE (IF KNOWN)

	YES	NO		YES	NO
HAVE YOU HAD AN ALLERGIC REACTION TO ANY MEDICINE? WHICH? ____________________ DESCRIBE REACTION:			DO YOU KNOW OF ANY CONDITION FOR WHICH YOU BELIEVE YOU NOW NEED OR WILL NEED TREATMENT? (MEDICINE, SURGERY OR PREGNANCY, ETC.) IF YES, WHAT? ___________________________________		
HAVE YOU EVER HAD A PNEUMONIA VACCINE?			HAVE YOU BEEN UNDER A PHYSICIAN'S CARE FOR A CHRONIC CONDITION? IF YES, WHY? ____________________________________		
HAVE YOU HAD AN ALLERGIC REACTION TO INSECT BITES OR STINGS? DESCRIBE:			HAVE YOU BEEN REJECTED FOR INSURANCE, MILITARY SERVICE OR EMPLOYMENT FOR A MEDICAL REASON? IF YES, WHY? ____________________________________		
DO YOU HAVE OTHER ALLERGIES: DESCRIBE:			HAVE YOU EVER HAD AN EYE EXAM? IF YES, WHEN WAS THE MOST RECENT? _____________		
DO YOU SMOKE? IF SO, HOW MANY PACKS PER DAY? _________ DID YOU EVER SMOKE? IF SO, HOW MANY PACKS PER DAY? _____ YRS? ______			HAVE YOU EVER BEEN EXPOSED TO HAZARDS AT YOUR JOB? WHAT HAZARD?___________________________________		
DO YOU DRINK ALCOHOL? (INCLUDING BEER) APPROXIMATE QUANTITY PER WEEK? ____________ IS THIS A PROBLEM FOR YOU OR YOUR EMPLOYER?			DO YOU USE SEATBELTS REGULARLY?		
DO YOU USE ANY STREET DRUGS? WHAT? _________________ HOW OFTEN?__________			DO YOU PRACTICE SAFE SEX? (MONOGAMOUS RELATIONSHIP / CONDOMS / CELIBATE)		
HAS A PSYCHIATRIST EVER TREATED YOU? IF YES, WHEN? ___________________________________ DID YOU RECEIVE IN-PATIENT TREATMENT? IF YES, WHEN? ___________________________________			DO YOU HAVE A LIVING WILL OR ADVANCE DIRECTIVES? IF NOT, ARE YOU INTERESTED IN MORE INFORMATION?		
LEARNING NEEDS ASSESSMENT ARE THERE ANY PERSONAL RELIGIOUS AND/OR CULTURAL ASPECTS WE NEED TO CONSIDER IN REGARDS TO LEARNING/TEACHING? IF SO, WHAT ARE THEY?			WHO LIVES WITH YOU?		
			DO YOU FEEL SAFE AT HOME?		
WHAT IS THE EASIEST WAY FOR YOU TO LEARN? o READING o LISTENING o DEMONSTRATION			HAVE YOU HAD CHICKEN POX AS A CHILD?		
DO YOU HAVE A PHYSICAL DISABILITY? IS YES, DESCRIBE.			DID YOU HAVE YOUR ANNUAL MEDCIAL PHYISCAL DONE? DATE:		

Patient Name:_____________________

DOB:__________________

FAMILY MEDICINE/INTERNAL MEDICINE
REVIEW OF SYSTEMS

FAMILY HISTORY: PLEASE CHECK BOX AND CIRCLE RELATIONSHIP TO YOU.
PGF: Paternal Grandfather PGM: Paternal Grandmother M: Mother F: Father
MGF: Material Grandfather MGM: Maternal Grandmother B: Brother S: Sister

Arthritis		PGF	PGM	MGF	MGM	M	F	B	S
Asthma/COPD		PGF	PGM	MGF	MGM	M	F	B	S
Cancer (type)__________		PGF	PGM	MGF	MGM	M	F	B	S
Coronary Artery Disease		PGF	PGM	MGF	MGM	M	F	B	S
Depression/Anxiety		PGF	PGM	MGF	MGM	M	F	B	S
Diabetes		PGF	PGM	MGF	MGM	M	F	B	S
GI Disorders		PGF	PGM	MGF	MGM	M	F	B	S
High Cholesterol		PGF	PGM	MGF	MGM	M	F	B	S
Hypertension		PGF	PGM	MGF	MGM	M	F	B	S
Migraines		PGF	PGM	MGF	MGM	M	F	B	S
Obesity		PGF	PGM	MGF	MGM	M	F	B	S
Stroke		PGF	PGM	MGF	MGM	M	F	B	S
Other: ___________		PGF	PGM	MGF	MGM	M	F	B	S

STATEMENT OF PRESENT HEALTH: (GIVE A DESCRIPTION OF PAST HISTORY, IF COMPLAINT EXISTS):

DO YOU FOLLOW A PARTICULAR DIET? *PLEASE CIRCLE ALL THAT APPLY*

· DIABETIC · LOW CALORIE · LOW CARB · LOW FAT · VEGETRAIN/VEGAN · OTHER______________________

DO YOU PARTICIPATE IN REGULAR EXERCISE? YES/NO FREQUENCY: ____ _
WHAT TYPE?____

HAVE YOU TRAVELED OUTSIDE THE UNITED STATES WITHIN THE PAST 5 YEARS? YES/NO

WHERE:____
WHEN:____

FEMALES ONLY:

WHEN WAS YOUR LAST MENSTRUAL PERIOD? ____
NUMBER OF PREGNACIES? ________________________ NUBMER OF BIRTHS?____
ARE YOU CURRENTLY ON ANY BIRTH CONTROL? YES/NO IF *YES,* PLEASE INDICATE: ____
WOULD YOU LIKE A PHYSICIAN TO DISCUSS FAMILY PLANNING WITH YOU? YES/NO

IMMUNIZATIONS:

INFLUENZA: YES/NO DATE:____________________
PNEUMOVAX: YES/NO DATE:____________________
TETANUS: YES/NO DATE:____________________
ZOSTAVAX (SHINGLES): YES/NO DATE:____________________
OTHER: ___________________ DATE:____________________

Patient Name:____________________
DOB:__________________

SYSTEM REVIEW: PLEASE CHECK THE APPROPRIATE BOX: FOR EACH PROBLEM CHECK NEVER, PAST OR NOW.

NEVER	PAST	NOW	HAVE YOU EVER HAD:
			GENERAL/CONSTITUTIONAL:
o	o	o	Unexplained weight loss or weight gain
o	o	o	Excessive fatigue
o	o	o	Difficulty performing daily activities such as: *bathing, cooking, cleaning*.
o	o	o	Prolonged fever/chills
o	o	o	Other:
			HEAD/EYES/EARS/NOSE/THROAT
o	o	o	Frequent or severe headaches
o	o	o	Wear glasses or contact lenses
o	o	o	Chronic nasal discharge, drainage or sneezing
o	o	o	Impaired hearing
o	o	o	Other:
			NEUROLOGICAL:
o	o	o	Memory loss
o	o	o	Fainting, dizziness, seizures, convulsions
o	o	o	Other:
			CARDIOVASCULAR
o	o	o	Rheumatic Fever
o	o	o	Pain or pressure in chest
o	o	o	Any heart trouble
o	o	o	Palpitation or pounding beat
o	o	o	Abnormal heart rhythm or murmur
o	o	o	Swelling of ankles
o	o	o	High blood pressure
o	o	o	Other:
			RESPIRATORY
o	o	o	Chronic cough
o	o	o	Asthma or wheezing
o	o	o	Shortness of breath at night
o	o	o	Shortness of breath anytime
o	o	o	Other:
			GASTROINTESTINAL
o	o	o	Abdominal pain
o	o	o	Loss of appetite
o	o	o	Change in bowel habits (constipation or diarrhea)
o	o	o	Blood in stool
o	o	o	Hemorrhoids or rectal disease
o	o	o	Nausea/vomiting
o	o	o	Other:
			GENITOURINARY
o	o	o	Frequent urination at night
o	o	o	Frequent or painful urination
o	o	o	Difficulty holding urine
o	o	o	Difficulty stopping or starting urine stream
o	o	o	Urinary tract infection
			MALE
o	o	o	Sores or discharge from penis
o	o	o	Lump or pain of testicle
o	o	o	Sexually transmitted disease
o	o	o	Condom use
o	o	o	Problems with sexual function

NEVER	PAST	NOW	HAVE YOU EVER HAD:
			FEMALE
o	o	o	Method of birth control if sexually active/heterosexual
o	o	o	Mid-cycle bleeding
o	o	o	Pain with intercourse
o	o	o	Vaginal discharge or sores
o	o	o	Painful periods
o	o	o	Sexually transmitted disease
o	o	o	Problem with sexual function
o	o	o	Periods regular
o	o	o	Pregnant
			MUSCULOSKELETAL
o	o	o	Pain in joints/arthritis
o	o	o	Chronic back pain or injury
o	o	o	Other:
			SKIN/BREAST
o	o	o	Change or new growth in mole
o	o	o	Breast lump
o	o	o	Breast nipple discharge
o	o	o	Other:
			EMOTIONAL
o	o	o	Trouble sleeping
o	o	o	Depression
o	o	o	Anxiety or nervousness
o	o	o	Loss of memory
o	o	o	Other:
			HEMATOLOGIC/LYMPH
o	o	o	Anemia
o	o	o	Excessive bleeding or abnormal bruising
o	o	o	A transfusion
o	o	o	Any swelling of lymph nodes
o	o	o	Other:
			ENDOCRINE
o	o	o	Cold or heat intolerance, any thyroid problems
o	o	o	Excessive thirst or hunger
o	o	o	Other:
			OPTIONAL
o	o	o	Are you sexually active
o	o	o	Are you sexually active with members of opposite sex o, same sex o , or both o
o	o	o	If sexually active with the opposite sex, do either of you use contraception (birth control?) If yes, what form?

REVIEWED BY PHYSICIAN

____ DATE __________

NAME: ____ DOB: _____________________________ DATE: ___________________

Patient Name:_____________________

DOB:__________________