MedStar Physician Partners

MPP Family Practice at Olney
18109 Prince Philip Drive
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Olney, Maryland 20832
Phone: 301-570-7770 Fax: 855-256-6851

Name _____ Date of Birth_____
Last First MI Preferred
Address_____ Phone (___)_____
Street Number Road Apt# Work #
_____ Phone (___)_____
City State Zip Home #

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)?
_____

_____

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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