MedStar Physician Partners

MedStar Health at Chevy Chase
5454 Wisconsin Ave, Suite 401
Chevy Chase, MD 20815
Phone: (877) 677-3627 Fax: (301) 215-4499

Name _____ Date of Birth_____
Last First MI

Address_____ Phone (___)_____
Street Number Road Apt# Work #

_____ Phone (___)_____
City State Zip Home #

Who referred you? _____

PAST MEDICAL HISTORY (Please check appropriate box.)

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

Patient's Name: _____ Date of Birth: _____

When was your last general/complete **physical** done? Date: _____
When was your last blood work: _____ Abnormal labs: _____
Last Prostate exam? _____ Last Colonoscopy? _____
Have you ever had an eye exam? If yes, when was the most recent?
Have you ever been exposed to hazards at your job? _____ If so, what? _____
Are you **sexually active**? ____ Do you practice Safe Sex? (Monogamous Relationship/Condoms/Celibate) ____
Are you sexually active with members of the opposite sex _____, same sex _____ or both _____
Do you have a physical disability? If yes, please describe. _____
Has a **Psychiatrist** ever treated you? If yes, when? _____
Did you receive In-Patient treatment? ____ If yes, when? _____
Have you ever been under a physician's care for a chronic condition? ____ If yes, what: _____

HAVE YOU EVER HAD A BLOOD TRANSFUSION? Please list how much blood you received, the date(s) and any reactions:

_____

EXERCISE:
Do you receive regular aerobic exercise? _____ If yes, what type? _____
How often per week? _____ Duration each time: _____

Do you follow a particular diet? **Please circle all that apply**

Diabetic Low Calorie Low Carb Low fat Vegetarian/Vegan Other: _____

PAST SURGICAL HISTORY:
Please list the reason for hospitalizations with the approximate date and the place

Reason	Date (Month/Year)	Hospital

Please list ALL medicines you take now (including Vitamins, Birth Control Pills and Over-the-counter drugs)

(MEDICINE AND DOSE)	(MEDICINE AND DOSE)

Patient's Name: _____ Date of Birth: _____

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 had an allergic reaction to insect bites of stings? Describe: _____

_____

FAMILY HISTORY

PLEASE CHECK BOX AND CIRCLE RELATIONSHIP TO YOU:
PGF: Paternal Grandfather PGM: Paternal Grandmother M: Mother F: Father
MGF: Maternal 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**

SOCIAL HISTORY

Where were you born and raised? _____
What is the highest level of education you have received? _____
What has been you main occupation and are you currently employed? _____
_____
What has been your most recent job? _____
Marital Status: _____ Children? _____ Religion: _____
Who lives in your household? _____
Do you feel safe at home? _____ If not, please explain: _____

Do you or have you ever **smoked** cigarettes, cigars, a pipe or other forms of tobacco?
Please supply details (when you started, quit, how much do/did you smoke): _____
_____

Do you drink **alcohol**? (including beer) Please supply details (how often, how much, when did you start)
Is this a problem for you or your employer? _____
Do you use caffeine (i.e. colas, coffee, teas, chocolate)? _____ If yes, please indicate: _____
Do you use street drugs? If so what, _____ How often? _____
Have you ever used intravenous **(IV)** drugs? _____

Patient's Name: _____ Date of Birth: _____

OTHER:

Do you have a living will or advanced directives? _____ If not, are you interested in more information?
Are you an organ donor? _____

IMMUNIZATIONS:
Please check appropriate box if immunized:

	YES	NO	DATE		YES	NO	DATE
Chicken Pox				Tetanus			
Mumps				Measles			
Rubella				Hepatitis B			
Influenza				Zostavax			
Pneumovax				Gardasil			

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: _____
Are you currently on Birth Control? _____ If yes, please indicate: _____
Last PAP? _____ Last Mammogram? _____

OBSTETRICAL HISTORY:

Are you pregnant? _____ Are you planning a pregnancy? _____
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: _____
_____

Revised 1-18-2013