Potomac Physician Associates, PC

Name:_____( ) Male ( ) Female Date:_____
Birthdate:_____Work #_____Home# _____ Cell#_____
Occupation: _____ Marital Status: S M D W (please circle)
Emergency Contact: _____
Relationship:_____
Phone number: _____ Other #: _____
Reason for today's visit: _____

PAST MEDICAL HISTORY

Check which condition(s) you are currently being treated for or have been in the past :

○Arthritis ○Depression/ Anxiety ○High cholesterol ○Stroke
○Asthma ○Headaches ○ Hypertension ○Thyroid Problems
○Birth defects ○Heart Attack ○ IBS/ Digestive problems ○Other _____
○Bleeding disorder/ Anemia ○ Seasonal allergies
○Heart Disease ○ Seizure Disorder
○Cancer ○Heartburn/ Ulcer ○ Sexually Transmitted Disease
□Type _____
□ What is the year of your last colonoscopy? _____

CURRENT MEDICATIONS

Medication Name Dosage # Times daily List any medications you are currently taking, please include any over the counter medications, vitamins, supplements etc…	**MEDICATION ALLERGIES** Please list any drug allergies with reactions:
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

SOCIAL HISTORY (please circle Yes or No)

Do you use tobacco? YES NO Formerly (year quit_____)
If yes what kind and how much per day? _____ # years _____

Do you drink alcohol? YES NO Formerly (year quit _____)
How many drinks per week? _____

Do you use drugs? YES NO Formerly (year quit_____)
If yes what types? _____ How many times per week? _____

Do you drink caffeinated beverages? YES NO
If yes how many per day? _____

Do you Exercise? YES NO
If yes how many times per week? _____

Do you wear a seatbelt? YES NO

Who else lives at home? _____
Do you feel safe at home? YES NO

************PLEASE TURN OVER AND COMPLETE************

SURGICAL HISTORY

List any in or out patient surgical procedures you have had, starting with the most recent.

Date	Surgery
1.	
2.	
3.	
4.	
5.	

Have you ever received a blood transfusion? **O Yes** **O No**

Gynecological History (for Women Only)
Date of last Pap smear _____ # pregnancies _____
Date of last mammogram _____# deliveries _____
Date of last bone density _____

FAMILY HISTORY

Has any member of you family had any of the following illnesses:
(Indicate relationship i.e., Mother, Father, Grandparent, Sibling)

□Asthma _____ □Diabetes_____ □Mental retardation _____
□Birth defects _____ □Heart attack_____ □Osteoporosis _____
○ Age diagnosed _____
□Bleeding problem/ Anemia _____ □Heart disease_____ ○ Age diagnosed _____ □Seizures_____
□Cancer _____ □High blood pressure_____ □Stroke_____
□Cystic fibrosis _____ □High cholesterol _____ □Thyroid problems_____
□Depression/anxiety _____ □IBS/Digestive problems_____ □Other _____

Living			**Current Age or Age at death**	**Cause of Death**
Mother	Yes	No	_____	_____
Father	Yes	No	_____	_____
Sister	Yes	No	_____	_____
Brother	Yes	No	_____	_____

Pharmacy Name: _____Telephone #_____

Address: _____

_____
Patient Signature Date

_____
Physician Signature Date