Potomac Physician Associates, PC

Name:_____ Preferred Pronoun: ( ) He ( ) She ( ) Decline
Gender Identity: ( ) M ( ) F ( ) FTM ( ) MTF ( ) Neither ( ) Decline
Birthdate:_____Work #_____Home# _____ Cell#_____
Occupation: _____ Marital Status: S M D W (please circle)
Emergency Contact: _____Relationship:_____
Phone number: _____ Alternate #: _____
Reason for today's visit: _____ Date:_____

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	○Heart Disease	○ Seasonal allergies ○ Seizure Disorder	
○Cancer	○Heartburn/ Ulcer	○ Sexually Transmitted Disease	

□Type _____

□ What is the year of your last colonoscopy? _____

CURRENT MEDICATIONS / MEDICATION ALLERGIES

Medication Name Dosage # Times daily List any medications you are currently taking, please include any over the counter medications, vitamins, supplements etc…	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_____ □Seizures_____
○ Age diagnosed _____
□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