Potomac Physician Associates, P.C.

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Name:___________________________ ( ) Male ( ) Female Date:_________________
Birth Date:____________Work #___________Home# ____________ Cell#__________
Occupation: ______________________ Marital Status: ____________________________
Reason for today's visit: ____
Emergency Contact: _________________ Phone number: ______________________

PERSONAL HISTORY

Check if you have chronic medical problems for which you are currently being treated:

☐ asthma _________________	☐ diabetes ______________	☐ mental retardation ____________
☐ birth defects _____________	☐ heart attack____________	☐ anxiety _____________________
☐ bleeding problem__________	☐ heart disease___________	☐ seizures ____________________
☐ cancer __________________	☐ high blood pressure_____	☐ stroke ______________________
☐ cystic fibrosis ____________	☐ high cholesterol________	☐ thyroid problems____________
☐ depression_______________	☐ other ____	

MEDICAL / SOCIAL Hx

MEDICATIONS	HABITS (please circle yes or no)
1. Non-Prescription (x any taken regularly) ☐ vitamins ☐ aspirin ☐ laxatives ☐ antacids ☐ decongestants ☐ Tylenol or Motrin Other:______________________________ 2. Prescriptions –(including birth control) Medication Dosage # times daily _____________________________________ _____________________________________ _____________________________________ _____________________________________ _____________________________________	Do You use Tobacco? YES NO What kind and how much? ___________ Do you drink alcohol? YES NO How much? _____________________ Do you use drugs? YES NO What types? _____________________________ Do you drink caffeinated beverages? YES NO Do you wear seat belts? YES NO Do you sleep well? YES NO Do you exercise regularly? YES NO Who else lives at home? _________________
IMMUNATIONS (X ANY RECEIVED) ☐ MMR ☐ HPV ☐ Hep B ☐ Meningitis ☐ Flu shot ☐ Pneumonia ☐ ___________ ☐ TB Skin test: Year: _____Pos: ___Neg:___ ☐ Tetanus Dates:_______________ ☐ Chicken Pox : Date: ________________	Have you ever experienced any of the following? ☐ marriage difficulties ☐ job difficulties ☐ sexual difficulties ☐ sexual abuse ☐ depression ☐ sleep difficulties ☐ emotional problems ☐sexually transmitted disease_______________ ____
ALLERGIES (x any you are allergic to) ☐ No Known Allergies ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Sulfa Insect Bites ☐ Other Of the following check ones you are allergic to: Specify types (s)__________________________________	**WOMEN ONLY:** Date of last Pap smear:_________________ Last Mammogram:__________ Pregnancies: ______________Deliveries:_______ Last menstrual cycle : ______________________ Last bone density test : ________________

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

List any hospital stays, including surgeries, starting with most recent.

DATE	REASON	HOSPITAL
1.		
2.		
3.		

Have you ever received any blood transfusions? O Yes O No

CONDITIONS

CHECK if you have NOW, or have EVER HAD any of the following conditions

- ☐ **unexpected weight changes, more than 10 lbs in the past year**
- ☐ **serious problems with eyes or ears**
- ☐ **persistent swollen glands/unusual lumps**
- ☐ **breast lump (s) or unusual discharge**
- ☐ **irregular or fast heartbeat**
- ☐ **chest pain or tightness**
- ☐ **frequent swelling of ankles or legs**
- ☐ **unusual or severe shortness of breath**
- ☐ **unusual skin problems or persistent sores**
- ☐ **redness, severe pain or swelling of joints**
- ☐ **frequent or severe back pain**
- ☐ **other:______________________________**

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- ☐ **changes in appetite**
- ☐ **difficulty swallowing**
- ☐ **frequent or severe abdominal pain**
- ☐ **frequent nausea or vomiting**
- ☐ **blood in bowel movement**
- ☐ **pain or burning with urination**
- ☐ **loss of control of urination**
- ☐ **genital problems**
- ☐ **problems with pregnancy**

FAMILY HISTORY

Check if there is anyone in your immediate family with a history of:
(Indicate relationship i.e., Mother, Father, Grandparent, Aunt, Sibling)

☐ asthma ___________	☐ diabetes ___________	☐ mental retardation ___________
☐ birth defects ___________	☐ heart attack___________	☐ anxiety ___________
☐ bleeding problem___________	☐ heart disease___________	☐ seizures ___________
☐ cancer ___________	☐ high blood pressure_____	☐ stroke ___________
☐ cystic fibrosis ___________	☐ high cholesterol________	☐ thyroid problems___________
☐ depression___________	☐ other ___________	

Pharmacy Name: ______________________Telephone #________________________
Address:

____

What questions do you wish to ask the doctor? ___________________________________

Do you wish to be an organ donor? ☐ YES ☐ NO

Do you have a living will? ☐ YES ☐ NO

____

Patient Signature Date

____

Physician Signature Date