Maryland Primary Care Physicians

Adult Patient Medical Questionnaire

Date: _____

Name: _____ _____ _____ Date of Birth: _____
LAST FIRST MIDDLE MM/DD/YYYY

CURRENT MEDICAL PROBLEMS

List any current medical problems or conditions.

1) _____ 7) _____
2) _____ 8) _____
3) _____ 9) _____
4) _____ 10) _____
5) _____ 11) _____
6) _____ 12) _____

ALLERGIES

List any allergies to medication, x-ray dyes, or food.

Allergy	**Reaction**

Rx

Local Pharmacy: _____ Mail Order Pharmacy: _____

MEDICATIONS

List any medication that you currently take, including over-the-counter.

Name	Strength	Direction	Prescribed by

PAST MEDICAL HISTORY

Antibiotic Prophylaxis

Medication	Condition	Medication	Condition
1)		**3)**	
2)		**4)**	

Childhood Illnesses

1) _____ **3)** _____ **5)** _____
2) _____ **4)** _____ **6)** _____

Patient Name: _____ **Date of Birth:** _____

PAST MEDICAL HISTORY (CONTINUED)

Chronic Illnesses

1) _____ **3)** _____ **5)** _____

2) _____ **4)** _____ **6)** _____

Last Eye Exam: _____

Last Dental Exam: _____

Accidents

Injury	Date	Injury	Date
1)		**3)**	
2)		**4)**	

Past Surgeries

Surgery	Date	Surgery	Date
1)		**4)**	
2)		**5)**	
3)		**6)**	

List Any Other Hospital Stays:

Reason	Date	Reason	Date
1)		**4)**	
2)		**5)**	
3)		**6)**	

Anesthesia History

Any problems with anesthesia? ☐ NO ☐ YES (If yes, please list)

_____

List Any Procedures

Procedure	Date	Procedure	Date
1)		**4)**	
2)		**5)**	
3)		**6)**	

Physicians/Practitioners You Currently See:

Name	Specialty	Name	Specialty
1)		**4)**	
2)		**5)**	
3)		**6)**	

Patient Name: _____ **Date of Birth:** _____

FAMILY HISTORY

Please list any health problems and causes of death if applicable.

Family Member	Age	History
Father		
Mother		
Brother(s)		
Sister(s)		
Mother's father		
Mother's mother		
Father's father		
Father's mother		

SOCIAL HISTORY

Do you drink alcohol?..... ☐ No ☐ Yes

If yes, how much? _____

Are you sexually active?..... ☐ No ☐ Yes

If yes, what form of contraception do you use?: _____

Do you consume caffeine? ..... ☐ No ☐ Yes

If yes, how much per day? _____

Diet: ☐Balanced ☐Vegetarian ☐Diabetic ☐Low Salt ☐Low Fat ☐Low Carb ☐Other: _____

Have you ever been in an abusive relationship? ..... ☐ No ☐ Yes

Are you afraid of your partner? ... ☐ No ☐ Yes

Education: ☐High School ☐College ☐Some College ☐Trade School ☐Other: _____

Do you do some form of regular exercise every day? ..... ☐ No ☐ Yes

If yes, how much? _____

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Other: _____

Occupation: _____

Place of Birth (City, State): _____

Have you lived abroad more than one month? ..... ☐No ☐Yes

If yes, where? _____

List everyone in your household, including pets:

_____ _____

_____ _____

_____ _____

Do you wear seatbelts? ..... ☐No. ☐Yes

Do you participate in any activities that put you at risk of getting AIDS? ..... ☐No ☐Yes

Do you smoke or chew tobacco:..... ☐No ☐Yes

If yes, how much: _____

Spouse's occupation: _____

Do you use recreational drugs:..... ☐No ☐Yes

If yes, what do you use? _____

HEALTH MAINTENANCE

Please record the last year you had the following. If you do not know, leave blank.

HepA_____
HepB_____
Flu vaccine (shot)_____
Pneumonia vaccine (shot) _____
Tuberculosis Test_____
Positive PPD_____
Tetanus Diphtheria vaccine (shot)_____
TdaP_____
Meningococcal_____
MMR_____
Zostavax_____

Bone Density Scan_____
Breast Exam_____
Cardiac Stress Test_____
Colonoscopy_____
EKG_____
Hearing Exam_____
Mammogram_____
Eye Exam_____
Pelvic Exam_____
PAP Smear/GYN_____
Physical Exam_____

Patient Name: _____ **Date of Birth:** _____

MENSTRUAL HISTORY

Date of last menstrual period: _____

Amount: ☐ Normal ☐ Light ☐ Heavy ☐ Other: _____

Duration: _____ days

Are periods regular? ☐ NO ☐ YES

How many days apart are periods? _____

Age of onset of period: _____

Age of cessation of periods: _____

Any abnormal PAP smears? ☐ NO ☐ YES

If yes, when _____

Diagnosed with any STD's? ☐ NO ☐ YES

If yes, what _____

PAST PREGNANCIES

Please note the number of:

Total Pregnancies: _____

Full term births: _____

Premature births: _____

Abortions – induced: _____

Abortions – spontaneous: _____

Pregnancies – Ectopic: _____

Pregnancies – Multiple births: _____

Living; _____

REVIEW OF SYSTEMS

Please check if you have had problems with or are presently experiencing problems with any of the following:

Skin
☐ Skin diseases

Eyes
☐ Eyes diseases

ENT
☐ Hay Fever
☐ Head or neck

Neck
☐ _____

Respiratory
☐ Shortness of breath
☐ Asthma
☐ Bronchitis
☐ Pneumonia
☐ Persistent cough

Cardiovascular
☐ High blood pressure
☐ Heart disease
☐ Chest pain
☐ Swollen ankles
☐ Palpitations
☐ Lightheadedness

Gastrointestinal
☐ Abdominal discomfort
☐ Indigestion
☐ Nausea
☐ Vomiting
☐ Constipation
☐ Diarrhea
☐ Blood in stool
☐ Ulcers
☐ Change in bowel habits
☐ Unexplained weight gain/loss
☐ Hemorrhoids
☐ Gall bladder disease
☐ Colitis

Genitourinary (Female)
☐ Frequent urination
☐ Kidney diseases
☐ Kidney stones
☐ Difficulty urinating

Genitourinary (Male)
☐ Frequent urination
☐ Kidney diseases
☐ Kidney stones
☐ Difficulty urinating

Musculoskeltal
☐ Arthritis
☐ Low back problems
☐ Gout

Neurological
☐ Headache

Endocrine
☐ Diabetes
☐ Thyroid disease

Psychiatric
☐ Anxiety
☐ Depression
☐ Alcohol abuse
☐ Drug abuse

Hematologic/Oncologic
☐ Cancer
☐ Blood disorders
☐ Anemia

Infectious Disease
☐ Venereal diseases
☐ Hepatitis or Jaundice
☐ T.B.
☐ Rheumatic fever

Breast
☐ _____

OTHER

Do you have an advanced directive (living will)? ☐ No ☐ Yes

Notes: _____

_____

_____

Authorized Signature: _____ Date: _____

Reviewed by: _____ Date: _____