

C M P Columbia Medical Practice
 Department of Family Practice

5450 Knoll North Drive # 250
 Columbia MD 21045
 410-964-6200

Date:

Last Name	First	Middle or Maiden	Home Phone	Office Phone
Title or Occupation		Work Location	Sex	Age
Home Address			Name of Emergency Contact and Phone #	

Do you have any present concerns regarding your health? If so, please specify.

When was your last physical exam and by whom?

Family History

Relation	Age	State of Health	If deceased, Cause of Death	Age at Death
Mother:				
Father:				
Brothers & Sisters:				
Children				

Has any blood relation (Parent, brother, sister, children, etc) had or has:

Check each item	NO	YES	Relationship to you
Asthma, Hay Fever, Hives			
Cancer/Type			
Diabetes			
Seizure			
Heart Disease/Early M I			
High Blood Pressure			
Arthritis			
Tuberculosis			
Kidney Disease			

Other significant family history:

What Medicines or other over-the-counter meds/supplements do you occasionally or regularly take? Dosage?

Allergies: Reactions: Medications:

Caffeine cups per day _____ Type: Never smoked _____ Smoking now _____ Used to Smoke _____ Number of packs per day _____ # of years _____ Number of packs per day _____ # of years _____

On the average, how much Alcohol do you take per day? TYPE: _____ None _____ Occasional Only _____ About one or two daily _____ About three or four daily _____ More than four daily

Immunizations Vaccinations or Innoculations _____ Small Pox Date _____ Other Date _____ _____ Tetanus toxoid Date _____ Polio Date _____

You have had: _____ TB skin test(PPD) Date _____ Reactive _____ Non-Reactive _____ Don't Know _____

Do you have any Regular Physical Exercise? No _____ Yes _____ If so, what - How often?

Medical History - Page 2

Patient:

Date:

Present Weight _____ Have you experienced a recent loss in weight? _____ A gain in weight? _____
 If yes, number of pounds _____ Over what period of time? _____

	NO	YES	What YEAR	NOW		NO	YES	What YEAR	NOW
Headache					Swollen or painful joints				
Head Injury					Back pain				
Eye Trouble					Rash				
Worn glasses or contacts					Reaction to medicine or drug				
Ear, Eye or Throat trouble					Type of reaction:				
Sinus Problems					Hay fever or allergy				
Cough					Dizziness or Faintness				
Cough up blood					Paralysis				
Shortness of Breath					Appendicitis				
Asthma					Goiter/Thyroid Problems				
Tuberculosis (TB)					Epilepsy				
Lived with anyone with TB					Complication of childhood dis.				
Pain or pressure in chest					Scarlet Fever				
Palpitation or pounding of heart					Rheumatic Fever				
High blood pressure					Tumor,growth,cyst or cancer				
Heart Murmur					Venereal Disease				
Severe tooth or gum trouble					Duodenal Ulcer/ Reflux disease				
Indigestion					Edema Legs				
Gall bladder trouble or gall stones					Psoriasis/Exzema				
Jaundice					Excessive Fatigue				
Persistent or recurrent diarrhea					Anxiety				
Hemorrhoids or rectal distress					Depression or excessive worry				
Rectal Bleeding					Insomnia				
Painful urination					Drug or narcotic habit				
Blood in urine					Anemia/Type				
Kidney stone									
Sugar in urine									
Albumin in urine									
Get up nights to urinate									
Check each item:						NO		YES	
Have you ever been denied life insurance or rated up because of your health?									
Have you ever worked with radioactive substances? If so, state where and when									
Have you ever had radiation treatment?									
Have you ever been advised to have an operation?									
Have you ever had an operation? If so, please list details below									
Have you ever had a serious illness? Please describe below.									
Have you ever had serious injuries (fractures) Please describe below.									

WOMEN ONLY:

Menstrual History: Age at onset _____ Interval between periods _____ Duration _____
 Date of last period _____ Anything unusual about periods?
 Date of last PAP _____ Date of last Mammogram _____
 Date of last DEXA _____ Date of last Colonoscopy _____