

## NEW PATIENT QUESTIONNAIRE

PARK MEDICAL ASSOCIATES, LLC ◇ 10755 FALLS RD. SUITE 200 ◇ LUTHERVILLE, MD 21093

*Please print this form, complete, and bring with you.*

Name:	DOB:	Age:	Date:
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Operation performed & Reason <i>(include any complications related to surgery/anesthesia)</i>		Date
1		
2		
3		
4		
5		
6		
7		
8		

Overnight Hospitalizations <i>(exclude Operations listed above)</i>		Date
1		
2		
3		
4		
5		

Medications (include prescription topicals)	Drug name	Strength	Doses/day	Drug Allergies	Drug name	Description of reaction				
	1					1				
	2					2				
	3					3				
	4				4					
					Vaccines	Name	Yes	No	Date	
	5					Tetanus <i>(in past 10 yrs.)</i>	<input type="checkbox"/>	<input type="checkbox"/>		
	6					Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>		
	7					Hepatitis A <i>(2 doses)</i>	<input type="checkbox"/>	<input type="checkbox"/>		
	8					Hepatitis B <i>(3 doses)</i>	<input type="checkbox"/>	<input type="checkbox"/>		
9				Other <i>(in past 3 yrs.)</i>						
10										

	Have you had:	Date	Result
<i>(If more than one, list only most recent)</i>	Colonoscopy		
	Bone density		
	Mammogram		
	GYN examination		
	Eye examination		
	Stress test		
	**MRI/CT scan <i>(indicate part of body)</i>		
<i>(in the past 12 months)</i>	**Blood work		
	**Chest X-ray		
	**Ekg		

*\*\* Bring reports if possible. (Actual films are not required.)*

Pregnancies	Number:	Live births:	Complications:
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### Pre-visit instructions for laboratory tests:

- ▶ Fast after 12:00 midnight the night before the exam. ▶ Patients may have water, black coffee, plain tea the morning of the exam. ▶ Medications are to be taken as usual except for patients using insulin. ▶ Patients taking insulin should bring a light breakfast and their insulin. Inject insulin & eat breakfast after blood is drawn.

*Please complete "Family Medical History" on the next page.*

**FAMILY MEDICAL HISTORY**

Name:		DOB:		Age:	Date:
<b>IMMEDIATE FAMILY</b>		Living? Yes No		Age	Include ALL sisters, brothers, daughters, sons, and indicate health status for each. Significant health issues (or cause of death)
<input type="checkbox"/> Mother		<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Father		<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Sister	<input type="checkbox"/> Brother	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Daughter	<input type="checkbox"/> Son	<input type="checkbox"/>	<input type="checkbox"/>		

<b>DISTANT RELATIVES</b>	PLEASE REPORT ANY DISEASES OR SIGNIFICANT HEALTH ISSUES IN GRANDPARENTS, AUNTS, UNCLAS, AND COUSINS. (INDICATE SPECIFIC RELATIVE, e.g. MATERNAL COUSIN)
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<b>Cancer</b>	
Type :	Relative(s):
Type :	Relative(s):
Type :	Relative(s):
Type :	Relative(s):
Type :	Relative(s):

<b>Rheumatoid arthritis, gout, or other crippling arthritis (indicate diagnosis for each relative affected)</b>	
Diagnosis:	Relative:
Diagnosis:	Relative:
Diagnosis:	Relative:

<b>Serious psychiatric illness (nervous breakdown, mental hospitalization, suicide attempt)</b>	
Diagnosis:	Relative:
Diagnosis:	Relative:
Diagnosis:	Relative:
Diagnosis:	Relative:

<b>Coronary artery disease (heart attack, angioplasty, bypass surgery). Indicate approximate age of onset for each relative.</b>	

<b>Aneurysm:</b>	<b>Stroke:</b>
<b>Kidney disease:</b>	<b>Peptic ulcer disease:</b>
<b>Kidney stones:</b>	<b>Tuberculosis:</b>
<b>Diabetes:</b>	<b>High blood pressure:</b>
<b>Other significant diseases (include those that "run in the family"):</b>	
Diagnosis:	Relative:
Diagnosis:	Relative:
Diagnosis:	Relative:
Diagnosis:	Relative:

*Thank you for helping us with this information. We look forward to seeing you.*