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:

	Operation performed & Reason *(include any complications related to surgery/anesthesia)*	Date
1		
2		
3		
4		
5		
6		
7		
8		

	Overnight Hospitalizations *(exclude Operations listed above)*	Date
1		
2		
3		
4		
5		

Medications (include prescription topicals)

	Drug name	Strength	Doses/day
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Drug Allergies

	Drug name	Description of reaction
1		
2		
3		
4		

Vaccines

Name	Yes	No	Date
Tetanus *(in past 10 yrs.)*	☐	☐	
Pneumonia	☐	☐	
Hepatitis A *(2 doses)*	☐	☐	
Hepatitis B *(3 doses)*	☐	☐	
Other (in past 3 yrs.)			

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

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

Pregnancies	Number:	Live births:	Complications:

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:

IMMEDIATE FAMILY	Living? Yes	No	Age	Include ALL sisters, brothers, daughters, sons, and indicate health status for each. Significant health issues (or cause of death)
☐ Mother	☐	☐		
☐ Father	☐	☐		
☐ Sister ☐ Brother	☐	☐		
☐ Sister ☐ Brother	☐	☐		
☐ Sister ☐ Brother	☐	☐		
☐ Sister ☐ Brother	☐	☐		
☐ Sister ☐ Brother	☐	☐		
☐ Sister ☐ Brother	☐	☐		
☐ Sister ☐ Brother	☐	☐		
☐ Sister ☐ Brother	☐	☐		
☐ Daughter ☐ Son	☐	☐		
☐ Daughter ☐ Son	☐	☐		
☐ Daughter ☐ Son	☐	☐		
☐ Daughter ☐ Son	☐	☐		
☐ Daughter ☐ Son	☐	☐		
☐ Daughter ☐ Son	☐	☐		
☐ Daughter ☐ Son	☐	☐		
☐ Daughter ☐ Son	☐	☐		

DISTANT RELATIVES	PLEASE REPORT ANY DISEASES OR SIGNIFICANT HEALTH ISSUES IN GRANDPARENTS, AUNTS, UNCLES, AND COUSINS. (INDICATE SPECIFIC RELATIVE, *e.g. MATERNAL* COUSIN)
Cancer	
Type :	Relative(s):
Type :	Relative(s):
Type :	Relative(s):
Type :	Relative(s):
Type :	Relative(s):
Rheumatoid arthritis, gout, or other crippling arthritis *(indicate diagnosis for each relative affected)*	
Diagnosis:	Relative:
Diagnosis:	Relative:
Diagnosis:	Relative:
Serious psychiatric illness *(nervous breakdown, mental hospitalization, suicide attempt)*	
Diagnosis:	Relative:
Diagnosis:	Relative:
Diagnosis:	Relative:
Diagnosis:	Relative:
Coronary artery disease *(heart attack, angioplasty, bypass surgery).* **Indicate approximate age of onset for each relative.**	
Aneurysm:	**Stroke:**
Kidney disease:	**Peptic ulcer disease:**
Kidney stones:	**Tuberculosis:**
Diabetes:	**High blood pressure:**
Other significant diseases *(include those that "run in the family")*:	
Diagnosis:	Relative:
Diagnosis:	Relative:
Diagnosis:	Relative:
Diagnosis:	Relative:

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