PHYSICIAN ASSOCIATES

6000 EXECUTIVE BLVD., STE. 300
ROCKVILLE, MD 20815

5530 WISCONSIN AVE., STE. 645
CHEVY CHASE, MD 20815

PT NAME:________________/DOB:________________/DATE:______________

LIST ALL ALLERGIES	ALLERGIC REACTION

MEDICATION NAME	STRENGTH	FREQUENCY

HEALTH MAINTENANCE

Last Colonoscopy (male/female >50)
Date:________________________

Last Mammogram (female >40)
Date:________________________

Last Papsmear
Date:________________________

Last PSA blood test (males >40)
Date:________________________

FAMILY HISTORY

BLOOD RELATIVES	HEALTH STATUS	AGE IF LIVING	AGE AT DEATH	CAUSE OF DEATH	ILLNESSES
FATHER					
MOTHER					
BROTHER(S)					
SISTER(S)					

IMMUNIZATION HISTORY

VACCINE	DATE
TETANUS	
PNEUMOCCOCAL	
INFLUENZA	
MMR	
POLIO	
TYPHOID	
GARDASIL	
ZOSTAVAX	
HEPATITIS A	
HEPATITIS B	

MISCELLANEOUS INFORMATION

Blood Type A+ B+ AB+ O+ A- B- AB- O-

Blood Transfusions

No. of transfusions:________________

Date(s):__________________________

Reason(s):____

Last Chest X-Ray

Date:__________________________

Normal____ Abnormal____

Last TB Skin Test

Date:__________________________

Positive____ Negative_____

Last EKG:_______________________

Last Eye Exam:___________________

SOCIAL/PREVENTION HISTORY

Alcohol use	yes / no	If yes, explain:________________
Caffeine use	yes / no	
Exercise regularly	yes / no	
Good sleep habits	yes / no	
Illegal drug use	yes / no	If yes, explain:________________
Tobacco use	yes / no	If yes, explain:________________
Do you wear seatbelts?	yes / no	If no, explain:________________
Have you ever engaged in any activity that puts you at risk of STD's/HIV	yes / no	If yes, explain:________________
Do you want to be tested for STD's/HIV	yes / no	
Are you in a relationship which you have been physically hurt/injured	yes / no	If yes, explain:________________
Do you ever feel afraid of your partner?	yes / no	

LIST ALL ILLNESSES/INJURIES AND SURGERIES	DATE	HOSPITAL OR PHYSICIAN