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