

PHYSICIAN ASSOCIATES

6000 Executive Blvd #300

Rockville, MD 20852

Patient Name: _____ DOB: _____ Date of Appt.: _____

List all Allergies	Allergic Reaction

Medication Name	Strength	Frequency

Health Maintenance

Date of Last Colonoscopy (patients over 50): _____

Date of Last Mammogram (female patients over 40): _____

Date of Last Papsmear (female patients): _____

Date of Last PSA Blood Test (male patients over 40): _____

Family History

Blood Relatives	Health Status	Age (if living)	Age at Death	Cause of Death	Illnesses
Father					
Mother					
Brother(s)					
Sister(s)					

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Immunization History

Vaccine	Date
Tetanus	
Pneumococcal	
Influenza	
MMR	
Polio	
Typhoid	
Gardasil	
Zostavax	
Hepatitis A	
Hepatitis B	
COVID-19	

Miscellaneous Information

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

Blood Transfusions

Number of Transfusions: _____

Date(s): _____

Reason(s): _____

Last Chest X-Ray

Date: _____

Normal _____ Abnormal _____

Last TB Skin Test

Date: _____

Positive _____ Negative _____

Date of Last EKG: _____

Date of Last Eye Exam: _____

Social/Prevention History

Alcohol Use	Yes	No	If yes, explain:
Caffeine Use	Yes	No	If yes, explain:
Exercise regularly	Yes	No	If yes, explain:
Good sleep habits	Yes	No	If yes, explain:
Illegal drug use	Yes	No	If yes, explain:
Tobacco Use	Yes	No	If yes, explain:

