MMG at OLD EMMORTON ROAD
2227 Old Emmorton Road, Suite 220
Bel Air, MD 21015
P 410-569-9040

Name: _____ **DOB**:_____ **Date**:_____

Appointment Date, Time and Provider:_____

PAST MEDICAL HISTORY- have you EVER had any of the following: (check all that apply)

□ Alcohol/Drug Use	□ Anxiety/Depression	□ Anemia	□ Asthma	□ Blood Clots	□ High Blood Pressure
□ Glaucoma	□ Heart Burn/GERD	□ Hepatitis	□ Herpes	□ Migraines	□ High Cholesterol
□ HIV	□ Kidney Disease	□ Liver Disease	□ Migraines	□ COPD	□ Heart Valve Issues
□ Prostate Problem	□ Bleeding/Clotting D/O	□ Seizure	□ Osteopenia	□ Osteoporosis	□ Atrial Fibrillation
□ Thyroid Disorder	□ Rheumatologic Disorder	□ Stroke	□ Diabetes	□ Pre- Diabetes	□ Heart Attack/Stent
□ Seasonal Allergies	□ Bladder Problems	□ Cancer	□ Pneumonia	□ Sleep Apnea	□ Arthritis _____

OTHER CONDITIONS: (specify any other medical conditions not listed above): _____
_____
_____

PAST SURGICAL HISTORY: (Please list all previous surgeries including approximate date)

1._____ 2. _____
3._____ 4. _____
5._____ 6. _____

History of reaction to anesthesia/surgery? □ No □ Yes:_____
Have you ever had a blood transfusion? □ No □ Yes:_____

CARE PROVIDERS: Other Physicians you see regularly and for what medical condition

1. _____
2. _____
3. _____
4. _____

VACCINES:

□ Tetanus _____ □ Pneumonia _____ □ Flu _____ □ COVID_____ □ Shingles _____

PREVENTATIVE – Have you ever had the following procedures/test done?

□ Last Colonoscopy _____ □ Last Mammogram _____
□ Last PAP Smear _____ □ Last DEXA/bone density scan _____
□ Last Dentist _____ □ Last Eye Exam _____

FAMILY HISTORY

FATHER: Alive □ Yes □ No, age of death _____
MOTHER: Alive □ Yes □ No, age of death _____
BROTHERS: Alive □ Yes □ No, age of death _____
SISTERS: Alive □ Yes □ No, age of death _____

HEALTH CONDITIONS:

Father: _____
Mother: _____
Brothers:_____
Sisters: _____

→ *ANY OTHER FIRST DEGREE RELATIVE:* _____

Name: _____ D**OB**:_____ **Date**:_____

SOCIAL HISTORY

TOBACCO USE: □ Never □ Former Smoker □ Yes

→ ***YES/FORMER***: How Much: _____ Age Started: _____ Age Quit: _____

SUBSTANCE USE: □ Never □ Former □ Yes

→ Use of what drugs? _____ Age Quit: _____

ALCOHOL USE*:* □ Never □ Former □ Yes

→ *YES/FORMER*: How Many Drinks/Episode: _____ Frequency: _____ Age Quit: _____

***EMPLOYMENT/SCHOOL*:** _____

EXERCISE: □ No □ Yes, frequency/week/duration _____

MARITAL STATUS: □ Single □ Partnered □ Married □ Separated □ Divorced □Widowed

DIET: □ Regular □ Vegetarian/Vegan □Diabetic □ Other_____

CAFFEINE USE: □ No □ Yes, cups per day _____

ALLERGIES: □ None □ Penicillin □ Latex □ Sulfa □ Codeine □ OTHER _____

REACTION: _____

MEDICATIONS: Please list all current medications and dosing that you are taking

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

REVIEW OF SYSTEMS:

GENERAL:	□ Weight Change	□ Chronic Fatigue	□ Night Sweats	
EYES:	□ Visual Changes	□ Eye Pain		
ENT:	□ Hearing Decreased	□ Difficulty Swallowing	□ Hoarseness	□ Chronic Sore Throat
CARDIAC:	□ Chest Pain	□ Palpitations	□ Syncope/Pass Out	
RESPIRATORY:	□ Chronic Cough	□ Wheezing	□ Shortness of Breath	
GASTRO:	□ Abdominal Pain	□ Stool Changes	□ Blood in Stool	□ Heart Burn
GU :	□ Blood in Urine	□ Incontinence	□ Frequency	□ Pain with Urination
MUSCULAR:	□ Joint Pain _____	□ Joint Redness	□ Joint Swelling	□ Chronic neck/back pain
SKIN:	□ Rash	□ Change to Moles		
NEURO:	□ Fainting	□ Seizures	□ Headache	□ Tremor
PSYCH:	□ Anxiety	□ Suicide Thoughts	□ Depression	□ Sleep Problems
ENDOCRINE:	□ Excessive Thirst	□ Excessive Urination	□ Intolerance Heat/Cold	
HEME:	□ Abnormal Bleeding	□ Abnormal Bruising		
ALLERGY:	□ Bee Allergy	□ Food Allergy	□ Hives	