15215 Shady Grove Rd. # 100
Rockville, MD 20850
(301) 519-0902
Fax (301) 519-0905

MEDICAL HISTORY QUESTIONNAIRE

Please list below current medications you are taking (including prescriptions, over the counter needs, vitamins, herbal supplements):

1. ____________________ 2. ____________________ 3. ____________________

4. ____________________ 5. ____________________ 6. ____________________

Have you ever had or do you currently have:

Bronchitis	❑ Yes	Aneurysm	❑ Yes	Kidney Disease/Failure	❑ Yes
Allergic Rhinitis	❑ Yes	Migraines or Recurring Headaches	❑ Yes	Dialysis	❑ Yes
Sinusitis	❑ Yes	Stroke or TIA	❑ Yes	Urinary Tract Infection	❑ Yes
Ear Infection	❑ Yes	Anxiety	❑ Yes	Enlarged Prostate or infection	❑ Yes
Emphysema / COPD	❑ Yes	Depression	❑ Yes	Pelvic Infections	❑ Yes
Asthma	❑ Yes	Bipolar Disorder	❑ Yes	Ovarian Cyst	❑ Yes
Lung Disease	❑ Yes	Acid Reflux	❑ Yes	Sexually Transmitted Disease	❑ Yes
High Blood Pressure	❑ Yes	Heart Burn	❑ Yes	HIV, Hepatitis	❑ Yes
Heart Disease	❑ Yes	Diabetes	❑ Yes	Thyroid Disease	❑ Yes
High Cholesterol	❑ Yes	Peptic Ulcer Disease	❑ Yes	Arthritis	❑ Yes
Inflammation of Vein	❑ Yes	Pancreatitis	❑ Yes	Gout	❑ Yes
Blood Clots / DVT	❑ Yes	Diverticulitis	❑ Yes	Artificial Joints	❑ Yes
Bleeding Disorder	❑ Yes	Intestinal or Colon Problems	❑ Yes	Fibromyalgia	❑ Yes
Fainting	❑ Yes	Gallbladder Disease / Gallstones	❑ Yes	Back Problems	❑ Yes
Seizures	❑ Yes	Liver Disease	❑ Yes	Skin Disorders	❑ Yes
Anemia	❑ Yes	Bladder or Kidney Infection	❑ Yes	Immunizations up to date?	❑ Yes
Cancer	❑ Yes	Kidney Stones	❑ Yes		

I have no history of significant medical problems ❑ Yes

List any other diseases or conditions: ____________________

Do you have any allergies? (Environmental and/or medications) ❑ Yes ❑ No

If yes, please explain: ____________________

Have you ever had a reaction to Novacaine, Lidocaine, bandages, or topical antibiotics (Neosporin)? ❑ Yes ❑ No

Are you Pregnant? ❑ Yes ❑ No Are you breastfeeding? ❑ Yes ❑ No

Surgeries:

❑ Appendectomy ❑ Back ❑ Gallbladder ❑ Heart Bypass

❑ Hysterectomy ❑ Pacemaker ❑ Tonsillectomy

Have you had any other surgeries? ❑ Yes ❑ No

Please specify: ____________________

Family Medical History:

	None	Diabetes	High Blood Pressure	Heart Disease	Other
Mother	❑	❑	❑	❑	____________
Father	❑	❑	❑	❑	____________
Sister	❑	❑	❑	❑	____________
Brother	❑	❑	❑	❑	____________
Daughter	❑	❑	❑	❑	____________
Son	❑	❑	❑	❑	____________

Social History:

Do you now or have you ever used alcohol?	❑ Yes	❑ No	How much: ________
Do you now or have you ever used tobacco?	❑ Yes	❑ No	How much: ________
Do you use any drugs (including marijuana)?	❑ Yes	❑ No	How much: ________

Name____________________ **Date**____________________

Physicians Now URGENT CARE
You Matter. We Care.

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COMPREHENSIVE REVIEW OF SYMPTOMS

Please check boxes that apply to you today:

Constitutional
- Loss of appetite ❑ Yes
- Fever ❑ Yes
- Weakness ❑ Yes

ENT
- Nose bleeds ❑ Yes
- Sore throat ❑ Yes
- Ear pain ❑ Yes

Ophthalmology
- Drainage from eyes ❑ Yes
- Blurring of vision ❑ Yes
- Eye irritation ❑ Yes

Cardiology
- Palpitations ❑ Yes
- Chest pain ❑ Yes

Respiratory
- Shortness of breath ❑ Yes
- Cough ❑ Yes
- Congestion ❑ Yes

Gastroenterology
- Diarrhea ❑ Yes
- Vomiting ❑ Yes
- Constipation ❑ Yes
- Nausea ❑ Yes
- Abdominal pain ❑ Yes

Urology
- Difficulty urinating ❑ Yes
- Blood in urine ❑ Yes
- Frequent urination ❑ Yes
- Urinary incontinence ❑ Yes

Genitourinary female
- Painful menstrual cycle ❑ Yes
- Pelvic pain ❑ Yes
- Irregular periods ❑ Yes
- Vaginal itching ❑ Yes
- Abnormal vaginal discharge ❑ Yes

Musculoskeletal
- Joint stiffness ❑ Yes
- Joint pain ❑ Yes
- Joint swelling ❑ Yes
- Back pain ❑ Yes
- Neck pain ❑ Yes
- Muscle aches ❑ Yes

Dermatology
- Itching ❑ Yes

Neurology
- Headache ❑ Yes
- Tingling/numbness ❑ Yes
- Dizziness ❑ Yes

Hematology / Lymphatic system
- Swollen glands ❑ Yes
- Fatigue ❑ Yes

Endocrinology
- Excessive thirst ❑ Yes
- Excessive sweat ❑ Yes
- Cold intolerance ❑ Yes
- Heat intolerance ❑ Yes

Allergy
- Runny nose ❑ Yes
- Itchy eyes ❑ Yes
- Sneezing ❑ Yes

Other
____

Name____ **Date**_____________________________