

Patient History Form, age 5-11

following, either in the child or a family
member?
Heart
Lungs
Head/ears/nose/throat
Abdomen/Stomach/Intestines
Muscles or Joints
Nervous system
Depression or Anxiety
High blood pressure
High cholesterol
Diabetes
Thyroid disease
Cancer
Skin
Other

Family History	Medical Problems
Mother	
Father	
Brothers/Sisters	
Other Health Histo	ry
s there a smoker ir	the home?
ast dental appoint	ment?
ast vision screen o	r eye doctor appointment?
s there a family or	as a contact with the
s there a family or uberculosis, Hepat	
uberculosis, Hepat nfectious disease c	of concern?
uberculosis, Hepat nfectious disease c are there any specif	of concern? fic concerns you would like
uberculosis, Hepat nfectious disease c	of concern? fic concerns you would like
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uberculosis, Hepat nfectious disease c are there any specif	of concern? fic concerns you would like

	List current medications, with dose and frequency, and any other vitamins and/or supplements taken by the child	
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1	Do you have a copy of the child's immunization record?If so, please bring to the appointment. If not, please ask us to make you a copy, or obtain from your prior provider.	

Patient History Form, age 12-21	Is there concern about the patient 's mental
Name	health or abilities in school? If the above answer is yes, please fill out a mental
value	health questionnaire- ask a staff member or
Date of Birth M or F	obtain from website link.
Current school/grade level	
Current job situation	Problems or concerns with any of the following, either in the child or a family
Parent/Guardian(s)	member?
rarent/Guardian(s)	Heart
	Lungs
Prior Primary Care Provider or other specialists	Head/ears/nose/throat
seen within past 2 years	Abdomen/Stomach/Intestines
	Muscles or Joints
Allergies or reactions to medications?	Nervous system
	Depression or Anxiety
Has the patient been hospitalized for illness or	High blood pressure
surgery since their last visit? Provide dates as well.	High cholesterol
	Diabetes
	Thyroid disease
Recent changes in family, living or school	Cancer
situation?	Skin
	Other

Family History Medical Problems	List current medications, with dose and
Mother	frequency, and any other vitamins and/or
	supplements taken by the patient
Father	
Brothers/Sisters	
Grandparents	
Other Health History	
Does the patient smoke?	
Is there a smoker in the household?	
Does the patient drink alcohol? If so, how	
often?	Do you have a copy of your immunization record? If so , please provide us
Has the patient used illegal drugs or had issues	with a copy. If not, please obtain one from us
with substance abuse?	or your prior provider.
Is the patient sexually active? Using	Does the patient have a diet which is well-
birth control?	rounded and includes fruits, vegetables,
Last dental appointment?	protein, and a small amount of fats on a daily
Last vision screen or eye doctor appointment?	basis? If not, what is missing?
Is there a family or household contact with HIV,	
tuberculosis, Hepatitis C or any other infectious disease of concern?	
- Concern.	
Are there any specific concerns you would like	
to address at this appointment?	



following?

Problems or concerns with any of the

Patient History Form, 22-39

Name	Heart
Date of Birth M or F	Lungs
Occupation/Employer	Head/ears/nose/throat
	Abdomen/Stomach/Intestines
Other physicians or specialists seen within past 2 years	Muscles or Joints
	Nervous system
	Depression or Anxiety
Allergies or reactions to medications?	High blood pressure
	High cholesterol
Have you been hospitalized for illness or surgery since your last visit? Provide dates as	Diabetes
well.	Thyroid disease
	Cancer
	Skin
	Other
	Recent changes in family, living or
Last dental exam?	employment situation?
Last eye exam?	
Women - last gynecologic exam?	

Family History Medical Problems	List current medications, with dose and
Mother	frequency, and any other vitamins and/or supplements
Father	
Brothers/Sisters	
Grandparents	
Health Habits	<u>Past Immunization History</u> -give approximate date or supply immunization record
Treatti Trasits	date or supply initialization record
Do you or did you ever smoke?	Tetanus/dT/Tdap?
Drink alcohol?	Pneumonia vaccine?
Routine exercise?	Flu shot?
Caffiene?	Hepatitis B?
Have you ever had a problem with alcohol	Gardasil (HPV)?
abuse or drug abuse (prescription or street drugs)?	Zostavax (Shingles)?
Have you ever been physically or sexually abused?	Other vaccines for school, travel, etc?
Are there any specific concerns you would like to address at this appointment?	
	Do you have an advanced directive or living will?If so, please provide us with a copy.
	If not, please talk to your provider about this. You can download the MOLST (Maryland Medical Order for Life-Sustaining Treatment) form and fill it out for this appointment.



Patient History Form, 40-64

Name	
Date of Birth M or F Occupation/Employer	Problems or concerns with any of the following?
· · · · · · · · · · · · · · · · · · ·	Heart
Other physicians or specialists seen within past 2 years	Lungs
	Head/ears/nose/throat
	Abdomen/Stomach/Intestines
	Muscles or Joints
Allergies or reactions to medications?	Nervous system
	Depression or Anxiety
Have you been hospitalized for illness or surgery since your last visit? Provide dates as	High blood pressure
well.	High cholesterol
	Diabetes
	Thyroid disease
Last dental exam?	Cancer
Last eye exam?	·Skin
Last colonoscopy?	SKIII
Women - last gynecologic exam?	Other
Last mammogram?	
Men – last PSA ?	

Recent changes in family, living or	List current medications, with dose and
employment situation?	frequency, and any other vitamins and/or
	supplements
Family History Medical Problems	
Mother	
Father	
Brothers/Sisters	
	Past Immunization History-give approximate
Grandparents	date or supply immunization record
	Tetanus/dT/Tdap?
	Pneumonia vaccine?
Health Habits	Flu shot?
	Hepatitis B?
Do you or did you ever smoke?	
Drink alcohol?	Gardasil (HPV)?
	Zostavax (Shingles)?
Routine exercise?	Zostavax (Simigles):
	Other vaccines for school, travel, etc?
Caffiene?	
Have you ever had a problem with alcohol	i
abuse or drug abuse (prescription or street	
drugs)?	
Have you ever been physically or sexually	Do you have an advanced directive or living
abused?	will?If so, please provide us with a
	сору.
Are there any specific concerns you would like	If not places talk to your provides to
to address at this appointment?	If not, please talk to your provider about this. You can download the MOLST (Maryland
	Medical Order for Life-Sustaining Treatment)
	form and fill it out for this appointment.



Patient History Form, 65-105

Name	Problems or concerns with any of the following?
Date of Birth M or F	Heart
Employed, Volunteer, Retired or Disabled?	Lungs
	Head/ears/nose/throat
Other physicians or specialists seen within past	Abdomen/Stomach/Intestines
2 years	Muscles or Joints
	Nervous system
	Depression or Anxiety
Allergies or reactions to medications?	High blood pressure
	High cholesterol
Have you been hospitalized for illness or	Diabetes
surgery since your last visit? Provide dates as well.	Thyroid disease
	Cancer
	Skin
Last dental exam?	Other
Last eye exam?	
Last colonoscopy?	Recent changes in family or living situation?
Women - last gynecologic exam?	
Last mammogram?	
Men – last PSA ?	

Family History Medical Problems	
Mother	
	List current medications, with dose and
Father	frequency, and any other vitamins and/or supplements
Brothers/Sisters	
Grandparents	
<u>Health Habits</u>	
Do you or did you ever smoke?	
Drink alcohol?	
Routine exercise?	Past Immunization History-give approximate
Caffiene?	date or supply immunization record
Have you ever had a problem with alcohol	Tetanus/dT/Tdap?
abuse or drug abuse (prescription or street drugs)?	Pneumonia vaccine?
	Flu shot?
Have you ever been physically or sexually abused?	
abuseu!	Hepatitis B?
Are there any specific concerns you would like to address at this appointment?	Gardasil (HPV)?
	Zostavax (Shingles)?
Do you have an advanced directive or living	Other vaccines for school, travel, etc?
will?If so, please provide us with a	
сору.	
If not, please talk to your provider about this.	If you are coming for a Medicare wellness
You can download the MOLST (Maryland	check-up, please be sure to fill out the
Medical Order for Life-Sustaining Treatment)	Medicare questionnaire
form and fill it out for this appointment.	1