UNIVERSITY OF MARYLAND UPPER CHESAPEAKE HEALTH
HARFORD PRIMARY CARE
BOX HILL OFFICE

3401 Box Hill Corporate Center Drive
Suite 100
Abingdon, Maryland 21009
410-671-0017 (FAX) 410-671-7072
Patient Portal www.nextmd.com

Stanley Kman, DO
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Dear New Patient,

We would like to take this opportunity to welcome you to our practice and to thank you for choosing our physicians to participate in your healthcare. We look forward to providing you with personalized, comprehensive health care focusing on wellness and prevention. As continuity and coordination of patient care is essential in meeting your healthcare needs, our physicians, nurses, medical assistants and office staff work closely in a "team approach" to support your patient care.

Our office is open **Monday through Thursday from 8:00am-5:00pm and Friday 8:00am-3pm**. Each provider has evening appointments once a week which are available **Tuesday or Thursday as late as 6:30pm**. Every effort is made to see our patients for medical problems during daytime hours. Please note that our schedulers are available every day and will do their best to accommodate you. **You can reach us by phone beginning at 9:00am** or can request an appointment through our patient portal once you are signed up and active. Booking an appointment is essential to ensuring all patients receive the time they require for quality medical care. After hours guidance for emergencies will be provided by the on-call physician, who can be reached by calling 410-836-6344.

As your primary care physician, we work collaboratively with University of Maryland Upper Chesapeake Health Hospitals and a wide range of UM UCH physician specialists and community specialists to coordinate all aspects of your patient care including inpatient hospitalization and specialty consultation care, as needed.

Before you visit, please notify your health insurance company of your new primary care provider if required. We also request that you contact your previous physician and specialists and request that a copy of your medical record besent to us.

Please fill out the enclosed forms and fax them to us at 410-671-7072 or bring them with you to your appointment. Please plan on arriving at least 15 minutes prior to your appointment time. During your initial visit, we will be reviewing your health status and these forms contain information necessary to complete this process. **Please bring your health insurance identification card as well as a photo I.D**. Please bring a **complete list of all of your medications**, as well as the strength and dose of each one.

Once again, we would like to thank you for choosing us as your primary health care provider. We look forward to working with you to help you achieve your best health.

Sincerely,

The Providers and Staff of Harford Primary Care at Box Hill

HARFORD PRIMARY CARE – BOX HILL

"Patient-Centered Medical Home"

Our office has achieved recognition as a Level II Patient-Centered Medical Home (PCMH), which is responsible for overseeing and managing all aspects of your healthcare. Our entire practice is designed to help you establish and meet your individualized healthcare goals. We will work with you to address any concerns you may have, help you establish specialized care when needed, and make sure that your plan of care is one you can live with. Your health care team includes a physician, a nurse, medical assistants, and support staff. It is important for you to select one of our clinicians as your primary provider in order to ensure continuity of care. Rest assured, however, our entire team is available to assist in your care whenever needed.

Access to Care

- The best way to stay healthy is to maintain regular, scheduled visits with your primary provider.
- We offer same-day appointments for urgent and routine care on a first-come first-served basis.
- Bring your insurance card and photo ID to every visit.
- If you cannot keep your appointment, we kindly request 24 hours notice.
- Update your information at each visit so we can always reach you.
- NextMD (www.nextmd.com) gives you 24-hour access to your health information, including the ability to send a message to your provider, request appointments, and request prescription refills.

Care Coordination

- If you have recently seen another provider, facility, or Emergency Room, bring your discharge papers and any reports you received with you to your next appointment.
- Bring a list of all current medications to every visit.
- Your provider wants to be engaged with other providers you see. Make sure we are aware of all health care services you're receiving so that we can effectively coordinate your care.

After-hours Advice

- For life-threatening emergencies, call 911 or go to your nearest Emergency Room.
- For urgent (non-life threatening) matters that cannot wait until the next business day, call our office at (410) 836-6344 and remain on the line to reach our answering service. Your call will be returned within 30 minutes.
- For routine matters, you can simply call our office the next business day or send us a message via the patient portal and we will respond the next business day.

New Patients

- We participate with most health plans. Call our office or contact your insurance company to determine if we participate with your plan.
- For help obtaining health insurance under the Affordable Care Act, call Maryland Health Connection at (855) 642-8572.
- If you are transferring your care from pediatrics or another internal medicine practice, be sure to complete an authorization from that provider for us to obtain your medical records to ensure continuity of care.
- As part of UM Upper Chesapeake Health, we can connect you to a range of providers, including:
  - OB/GYN
  - Endocrinology
  - Behavioral Health
  - Gastroenterology
  - Cardiology
  - General Surgery
  - Dermatology
  - Ear, Nose, & Throat
  - Orthopedics
  - Hematology/Oncology
  - Radiation Oncology
  - Ophthalmology

Patient History Questionnaire

NAME: _____ DATE OF BIRTH: _____

Previous medical providers name and address: _____

_____

Emergency contact name (and relation to patient) and phone number:

_____

ALLERGIES: _____

MEDICATIONS (prescription & over the counter medicine) include name, dosage and frequency:

1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.
7.	14.

MEDICAL CONDITIONS, ILLNESSES, INJURIES, HOSPITALIZATIONS:

PROBLEM/DATE	PROBLEM/DATE	PROBLEM/DATE

Have you had a transfusion of blood or blood products? ☐ Yes ☐ No If yes, did you have any reaction? ☐ Yes ☐ No

PERSONAL & SOCIAL HISTORY

ALCOHOL/TOBACCO/DRUGS RISK SCREEN:

Do you use cigarettes, pipes, cigars or chewing tobacco? ☐ Yes ☐ No

Do you drink alcohol?

- Ever tried to cut back on the amount of alcohol you drink? ☐ Yes ☐ No
- Ever become angry when people discuss your alcohol? ☐ Yes ☐ No
- Ever felt guilty about anything you did because of your drinking? ☐ Yes ☐ No
- Ever had a drink before noon (eye opener)? ☐ Yes ☐ No
- Has your drinking affected your relationship with your family or friends? ☐ Yes ☐ No
- Has your drinking affected your work or school? ☐ Yes ☐ No
- Have you ever drunk alcohol while or before driving or driven while intoxicated? ☐ Yes ☐ No

Do you drink coffee, sodas or other caffeinated beverages? ☐ Yes ☐ No

Do you use any street drugs or abuse prescription pain medication? ☐ Yes ☐ No

SOCIAL HISTORY

Do you think you are at risk for HIV, AIDS or other sexually transmitted disease? ☐ Yes ☐ No

Have you ever been tested for HIV? ☐ Yes ☐ No

If yes, when ____/____ What was the result? ____

Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widow(er) ☐ Separated

Education: ☐ Jr. High School ☐ High School/GED ☐ Vocational School ☐ College ☐ Other

Occupation: _____ Do you have an Advance Directive? ☐ Yes ☐ No

FAMILY HISTORY

FAMILY MEMBER	AGE	ALIVE/DECEASED	HEALTH	CAUSE OF DEATH
Father				
Mother				
1.				
2.				

NAME: _____ DATE OF BIRTH: _____

FAMILY HISTORY		RELATIVE			RELATIVE
Alzheimer's Disease	☐ Yes ☐ No		Iron Storage Disease	☐ Yes ☐ No	
Breast Cancer	☐ Yes ☐ No		High Blood Pressure	☐ Yes ☐ No	
Heart Disease	☐ Yes ☐ No		Ovarian Cancer	☐ Yes ☐ No	
Stroke	☐ Yes ☐ No		Prostate Cancer	☐ Yes ☐ No	
Depression, Suicide	☐ Yes ☐ No		Skin Cancer	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No		Thyroid Disease	☐ Yes ☐ No	
High Cholesterol	☐ Yes ☐ No		Sickle Cell Disease	☐ Yes ☐ No	
Obesity	☐ Yes ☐ No		Anemia	☐ Yes ☐ No	
Glaucoma	☐ Yes ☐ No		Macular Degeneration	☐ Yes ☐ No	
Substance Abuse	☐ Yes ☐ No		Other	☐ Yes ☐ No	

HEALTH MAINTENANCE

Last stools, occult blood test: ____/____ Colonoscopy/Sigmoidoscopy: ____/____ Where _____

Dilated Eye Exam: ____/____ Where _____ Foot Exam: ____/____ Where _____

WOMEN: Last PAP smear: ____/____ Mammogram: ____/____ Breast Exam: ____/____ Where _____

Menstrual Period: ____/____

MEN: Last Rectal/Prostate exam: ____/____ Testicular exam: ____/____ PSA: ___/____

IMMUNIZATIONS: (last date/year received) Tetanus: ___/_____ Hepatitis B vaccine: ____/____ MMR: ___/_____

Pneumonia: (Type) ___/_____ Flu: ___/_____ Where _____ Tuberculosis Skin Test (date & results): ___/_____

Please review the list of symptoms below

Check "Yes" box if you suffer from the symptoms or have any of the health issues listed in the past 6 months: Check "No" box if you do not.

CONSTITUTIONAL		**SKIN**		**MUSCULAR SKELETAL**	
Unexplained weight loss	☐ Yes ☐ No	Skin change	☐ Yes ☐ No	Neck pain	☐ Yes ☐ No
Unexplained weight gain	☐ Yes ☐ No	Skin lesions	☐ Yes ☐ No	Gout	☐ Yes ☐ No
Fever	☐ Yes ☐ No	Skin itching	☐ Yes ☐ No	Injury to limbs	☐ Yes ☐ No
Chills	☐ Yes ☐ No	Rashes	☐ Yes ☐ No	Joint pain	☐ Yes ☐ No
Fatigue	☐ Yes ☐ No	Dry skin	☐ Yes ☐ No	Joint stiffness	☐ Yes ☐ No
Nausea or Vomiting	☐ Yes ☐ No	**GASTROINTESTINAL**	☐ Yes ☐ No	Locking joints	☐ Yes ☐ No
Eyes	☐ Yes ☐ No	Blood in stool	☐ Yes ☐ No	Back pain	☐ Yes ☐ No
Cataract	☐ Yes ☐ No	Change in movements	☐ Yes ☐ No	Red or swollen in joints	☐ Yes ☐ No
Change in vision	☐ Yes ☐ No	Constipation	☐ Yes ☐ No	**HEMATOLOGY/ONCOLOGY**	☐ Yes ☐ No
Glasses	☐ Yes ☐ No	Diarrhea	☐ Yes ☐ No	Anemia or low blood	☐ Yes ☐ No
Red eyes	☐ Yes ☐ No	Difficulty swallowing	☐ Yes ☐ No	Easily bruise	☐ Yes ☐ No
ENMT	☐ Yes ☐ No	Heart burn	☐ Yes ☐ No	Swollen lymph nodes	☐ Yes ☐ No
Bleeding from gums	☐ Yes ☐ No	Hemorrhoids	☐ Yes ☐ No	Cancers	☐ Yes ☐ No
Problems hearing	☐ Yes ☐ No	Black tarry stool	☐ Yes ☐ No	**PSYCHIATRIC**	☐ Yes ☐ No
Change in your voice	☐ Yes ☐ No	Nausea or vomiting	☐ Yes ☐ No	Depression or sadness	☐ Yes ☐ No
Denture	☐ Yes ☐ No	Stomach ulcers	☐ Yes ☐ No	Feel like hurting someone	☐ Yes ☐ No
Nose bleeds	☐ Yes ☐ No	**GENITOURINARY**	☐ Yes ☐ No	Feel like hurting yourself	☐ Yes ☐ No
Hoarse voice	☐ Yes ☐ No	Problems urinating	☐ Yes ☐ No	Problems with memory	☐ Yes ☐ No
Sinus problems	☐ Yes ☐ No	Blood in urine	☐ Yes ☐ No	Anxiety	☐ Yes ☐ No
Ringing in ears	☐ Yes ☐ No	Hernias	☐ Yes ☐ No	Problems concentrating	☐ Yes ☐ No
Mouth ulcers	☐ Yes ☐ No	Incontinence	☐ Yes ☐ No	Problems sleeping	☐ Yes ☐ No
CARDIOVASCULAR	☐ Yes ☐ No	Urination at night	☐ Yes ☐ No	**NEUROLOGY**	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Sexual transmitted disease	☐ Yes ☐ No	Change in memory	☐ Yes ☐ No
Heart problems	☐ Yes ☐ No	Urinary urgency	☐ Yes ☐ No	Dizziness	☐ Yes ☐ No
Chest pain	☐ Yes ☐ No	**WOMEN ONLY**	☐ Yes ☐ No	Headaches	☐ Yes ☐ No
Leg pain with walking	☐ Yes ☐ No	Problems with your period	☐ Yes ☐ No	Imbalance	☐ Yes ☐ No
Problems with exercise	☐ Yes ☐ No	Vaginal dryness	☐ Yes ☐ No	Numbness	☐ Yes ☐ No
Swelling in legs	☐ Yes ☐ No	Problems with sex	☐ Yes ☐ No	Weakness	☐ Yes ☐ No
Problems lying flat	☐ Yes ☐ No	Vaginal discharge	☐ Yes ☐ No	Tremors	☐ Yes ☐ No
Skipping heart beats	☐ Yes ☐ No	Pain in breast	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Short of breath at night	☐ Yes ☐ No	Lumps in breast	☐ Yes ☐ No	**ENDOCRINE**	☐ Yes ☐ No
RESPIRATORY	☐ Yes ☐ No	Breast discharge	☐ Yes ☐ No	Problems with heat	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	**MEN ONLY**	☐ Yes ☐ No	Problems with cold	☐ Yes ☐ No
Cough	☐ Yes ☐ No	Problems with erections	☐ Yes ☐ No	Swelling in neck	☐ Yes ☐ No
Coughing up blood	☐ Yes ☐ No	Dribbling of urine	☐ Yes ☐ No	Frequent urination	☐ Yes ☐ No
Shortness of breath	☐ Yes ☐ No	Weak urine stream	☐ Yes ☐ No	Excessive thirst	☐ Yes ☐ No
Wheezing	☐ Yes ☐ No	Pain in testicles	☐ Yes ☐ No	Changes in hair	☐ Yes ☐ No