UNIVERSITY of MARYLAND
UPPER CHESAPEAKE MEDICAL CENTER

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MEDICAL HISTORY FORM

Today's Date: ____________________

Patient Information

Please complete this form in its entirety and bring it with you to your scheduled appointment.

Name: ____ Birth Date: ______________ Sex: ☐M ☐F

Address: ____ Apt#: __________

City: ____ State: __________ Zip: ____________

Day Phone: ____________________________________ Place of Residence: _______________________________

Referring Physician: _____________________________ Family Physician: _________________________________

Reason for Referral: ____

Is this a MVA related injury? ☐ Y ☐ N • Is this a work related injury? ☐ Y ☐ N • Is this a non-work related injury? ☐ Y ☐ N

Are you diabetic? ☐ Y ☐ N • If yes, what was your last HgA1C Number? ______ • Where drawn? ____________________

Previous ulceration? ☐ Y ☐ N

Date of Onset: _______________________ Wound Cause: ____

Wound Treatment: ____

____

Allergies: Include all allergies and reaction		

Medications: Include all medications, dosages and frequency.	
1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.
7.	14.

☐Please see attached

Pharmacy Name: ____ Phone Number: _________________________

Medical Background: Check all that apply (include date if applicable- month/year)		
☐ Acute Respiratory Syndrome	☐ Eczema	☐ Myocardial Infarction (MI)
☐ Adrenal Disease	☐ Emphysema	☐ Neuropathy
☐ AIDS	☐ End stage renal disease	☐ Obesity
☐ Alopecia	☐ Epidermolysis Bullosa	☐ Onychomycosis
☐ Alzheimer's	☐ Epilepsy	☐ Osteoarthritis
☐ Amyotrophic lateral sclerosis	☐ Fibromyalgia	☐ Osteomyelitis
☐ Anemia	☐ Fistula	☐ Osteoporosis
☐ Angina	☐ Fracture	☐ Pancreatitis
☐ Anticoagulant Therapy	☐ Fungal Infection	☐ Paralysis
☐ Anxiety	☐ GERD	☐ Paraplegia
☐ Arrhythmia	☐ Gestational Diabetes	☐ Peptic Ulcer Disease
☐ Arthritis	☐ GI Bleed	☐ Peripheral Artery Disease
☐ Asthma	☐ Glasses	☐ Peripheral Vascular Disease
☐ Assistive Devices	☐ Glaucoma	☐ Phlebitis
☐ Atrial Fibrillation	☐ Gout	☐ Pleural Effusion
☐ Benign Prostrate Hyperplasia	☐ Head injury/LOC	☐ Pneumonia
☐ Bipolar Disorder	☐ Heart Disease	☐ Pneumothorax
☐ Bleeding/Clotting Disorders	☐ Hemosiderin Staining	☐ Positive TB test
☐ Buerger's Disease	☐ Hepatitis	☐ Prostate Cancer
☐ Cataracts	☐ Hiatal Hernia	☐ Psoriasis
☐ Charcot Foot	☐ HIV Positive	☐ Pulmonary Embolus
☐ Chronic Bronchitis	☐ Hypercholesterolemia	☐ Pyoderma
☐ COPD	☐ Hyperlipidemia	☐ Quadriplegia
☐ Chronic Pain Syndrome	☐ Hypertension	☐ Raynaud's Disease
☐ Cirrhosis	☐ Immune Deficiency	☐ Respiratory Failure
☐ CNS Trauma/Spinal Cord injury	☐ Inflammatory bowel disease	☐ Retinopathy
☐ Colon Cancer	☐ Intracranial bleed	☐ Rheumatoid Arthritis
☐ Congestive Heart Failure	☐ Kidney disease	☐ Schizophrenia
☐ Contractures	☐ Kidney stones	☐ Scleroderma
☐ Coronary Artery Disease	☐ Leukemia	☐ Seizures
☐ Cortisone Treatment	☐ Lupus	☐ Sickle Cell Anemia
☐ Crohn's Disease	☐ Lymphedema	☐ Sleep Apnea
☐ CVA (Stroke)	☐ Lymphoma	☐ Spina Bifida
☐ Deep Vein thrombosis (DVT)	☐ Macular Degeneration	☐ Thyroid Disease
☐ Depression	☐ Malnourished	☐ Type I Diabetes
☐ Dermatitis	☐ Memory Loss	☐ Type II Diabetes
☐ Diabetic Neuropathy	☐ Mental Disorder	☐ Ulcerative Colitis
☐ Dialysis	☐ Mitral Valve Prolapse	☐ Urinary/Fecal Incontinence
☐ Diverticulitis	☐ Morbid Obesity	☐ Varicose Veins
☐ Dysphasia	☐ MRSA	☐ Venous Insufficiency
☐ Eating Disorder	☐ Multiple Sclerosis	☐ Cancer____________________
☐ Other____________________	☐ Other____________________	☐ Other_____________________

During the last month, have you often been bothered by feeling down, depressed or hopeless?	☐ Y ☐ N
Would you like information/resources regarding depression?	☐ Y ☐ N
Do you have thoughts and/or a plan of self-harm?	☐ Y ☐ N

Surgical History: List any previous surgeries/hospitalizations and corresponding dates

Surgeries/Operations	Date	Hospitalizations (other than surgeries)	Date

Family History: Check all that apply.

Condition	Mother	Maternal Grandparents	Father	Paternal Grandparents	Sibling	Child	No History	Notes
Unknown History	☐	☐	☐	☐	☐	☐	☐	
Cancer	☐	☐	☐	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	☐	☐	☐	
Heart Disease	☐	☐	☐	☐	☐	☐	☐	
Hypertension	☐	☐	☐	☐	☐	☐	☐	
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	
Lung Disease	☐	☐	☐	☐	☐	☐	☐	
Mental Illness	☐	☐	☐	☐	☐	☐	☐	
Stroke	☐	☐	☐	☐	☐	☐	☐	
Thyroid Problems	☐	☐	☐	☐	☐	☐	☐	
Seizures	☐	☐	☐	☐	☐	☐	☐	
Other	☐	☐	☐	☐	☐	☐	☐	
None	☐	☐	☐	☐	☐	☐	☐	
Non Contributory	☐	☐	☐	☐	☐	☐	☐	

Social History

Weight:	Height:	Comments:
Have you ever smoked? ☐ Y ☐ N	How many years? / Packs per day?	Quit date:
Marital status :	Financial concerns? ☐ Y ☐ N	Comments:
Occupation: Completed Education Level:	Food, clothing, sheltering needs? ☐ Y ☐ N	Comments:
Children: ☐ Y ☐ N	Transport concerns? ☐ Y ☐ N	Comments:
Alcohol Use: ☐ None ☐ Rarely ☐ Occasionally ☐ Often		Comments:
Substance abuse ☐ Y ☐ N	Are you independent? ☐ Y ☐ N	Comments:
Glasses/Contacts ☐ Y ☐ N	Difficulty hearing? ☐ Y ☐ N	Comments:
Who do you live with?	Cultural or Religious Concerns? ☐ Y ☐ N	Comments:
Learning Method: ☐ Verbal ☐ Demonstration ☐ Written	Able to care for yourself? ☐ Y ☐ N	Comments:

If yes, please explain in the comments section