Upper Chesapeake Primary Care • Swan Creek Office

Robert Rapp, MD • Barbara Lewis, CRNP

Thank you for choosing Upper Chesapeake Primary Care for your healthcare needs. We look forward to working with you. Below, you will find general information about our office. Please keep this page for your records.

Address:	2027 Pulaski Highway Suite 203 Swan Creek Village Center Havre de Grace, MD 21078
Phone:	(443) 843-6262
Fax:	(443) 843-6264
Patient Portal:	www.nextmd.com
Appointment Hours:	Monday – Friday 7:00am – 4:00pm
Phone Hours:	Monday – Friday 8:00am - 4:00pm
Nights/Weekends:	For life-threatening emergencies, call 911 or report to your nearest Emergency Room. For urgent matters that cannot wait until the next business day, call our answering service at (410) 836-6213. Your call will be returned within 30 minutes. For routine matters, you can simply call our office to leave a message or send us a message via the patient portal and we will respond the next business day.

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: ____/____

Dental Exam: ____/____ Dilated Eye Exam: ____/____ Foot Exam: ____/____

WOMEN: Last PAP smear: ____/____ Mammogram: ____/____ Breast Exam: ____/____ Menstrual Period: ____/____

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

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

Pneumonia: _____ Flu: _____ 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

Upper Chesapeake Primary Care – Swan Creek

Authorization to Release Patient Health Information

Patient Name _____ Date of Birth _____/_____/_____

Daytime Telephone _____ Social Security No: _____

I authorize the following organization to release information as stated below from the patient health information record. This authorization covers the time period beginning: ____/____/____ and ending ____/____/____.

INFORMATION TO BE RELEASED FROM:

_____

Organization/Contact Name

_____

Street Address

_____

City, State, Zip

_____

Telephone Number

INFORMATION TO BE RELEASED TO:

Upper Chesapeake Primary Care, LLC
2027 Pulaski Highway
Suite 203
Havre de Grace, MD 21078
443-843-6262
443-843-6264 FAX

TYPES OF RECORDS REQUESTED (Charges for copies of records may be associated with your request).

□ Health care information related to the following treatment or condition _____
_____

□ Laboratory/diagnostic tests _____
_____

□ Other _____
_____

Purpose or need for this information: □ Continuing Care □ Copies for Own Use □ Other

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective when Upper Chesapeake Primary Care has already relied on the use or disclosure of the health information or if my authorization was obtained as a condition or obtaining insurance coverage and the insurer has a legal right to contest a claim. To revoke an authorization, complete a Revocation of Authorization form, which are available in each Upper Chesapeake Primary Care office.

I am authorizing disclosure of information protected under federal law. This information, once disclosed, may be subject to redisclosure by the recipient and no longer be protected by federal or state law. I understand that I do have to sign this authorization in order to get health care benefits (treatment, payment, enrollment or eligibility for benefits).

I acknowledge that I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree and authorize the release of patient health information to the above name person or organization. This authorization is valid for one year from the date signed, unless I revoke this authorization. Upper Chesapeake Primary Care may contact me to extend this authorization, but I do not have to do so.

_____ _____ _____

Date Signature of Patient or Legally Responsible Party Authority to Sign, if not Patient

Upper Chesapeake Primary Care – Swan Creek

"Patient-Centered Medical Home"

Our office is currently pursuing recognition as a 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, nurse practitioner, 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.
- 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 matters that cannot wait until the next business day, call our answering service at (410) 836-6213. Your call will be returned within 30 minutes.
- For routine matters, you can simply call our office to leave a message 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 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