Upper Chesapeake Primary Care-Forest Hill

Patient Information

Name: ____ Date: ______________________

Address: _____________________________________ Birthdate: ____________________

City/ST/Zip: ____________________________ Home Phone:_______________________

Cell Number: _____________________ Social Security Number: ____________________

Occupation: ___________________________ Employer:___________________________

Work Number: _____________________ Email address: __________________________

Marital Status (please circle one) S M W D Sep

Ethnicity: Hispanic/Latino Not Hispanic/Latino

Race: African American Asian Caucasian Hispanic Other

Preferred Language: __________________________

Insurance Information

Primary Insurance:________________________

Policy Holder: _______________________ DOB_____________

Secondary Insurance:________________________

Policy Holder: _______________________ DOB_____________

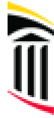
Emergency Contact:

Name: _________________________________ Relationship: ______________________

Address: ____

Phone Number: __________________________________

Patient Name:____



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General Information

Pharmacy:______________________________ Location: __________________________

Patient History:

Reason for today's visit: ____

Allergies/Reaction:____

☐ **Or check: No known drug allergies**

Current medications:

____

____

____

☐ **Or check: No medications**

Please list any previous surgeries or attach list:

____

____

____

____

List any significant hospitalizations:

____

____

Patient Name:____

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Please check if you have a history of, or currently have, any of the following.

CARDIOVASCULAR	**Yes**	**No**	**RESPIRATORY**	**Yes**	**No**
Hypertension			Asthma		
High Cholesterol			COPD		
Heart Disease			Use Oxygen		
Heart Attack			**NEUROLOGICAL**		
Congestive Heart Failure			Migraines		
Stroke			Seizure		
Pacemaker			Parkinson's		
Cardiac Stent			Neuropathy		
Bypass Surgery			**PSYCHIATRIC**		
ENDOCRINE			Depression		
Diabetes			Anxiety		
Hyperthyroidism			PTSD		
Hypothyroidism			Bipolar		
GASTROINTESTINAL			**HEMATOLOGICAL LYMPHATIC**		
Acid Reflux			Anemia		
Hepatitis			Bleeding Disorder		
Irritable bowel			Cancer		
MUSCULOSKELETAL			TB		
Arthritis			AIDS/HIV		
Rheumatoid			**GENITOURINARY**		
Osteoporosis			Bladder Problems		
Osteopenia			Prostate Problems		
CONSTITUTIONAL					
Weight Loss			**OTHER**		
Weight Gain					

For Women Only

Do you perform self-breast exams? No _________ Yes___________

Last Mammogram: ___________________________ Last breast exam:_________________

Last Menstrual:__________________________ Last Pap Smear: _______________________

Age of first pregnancy: ___________________ Number of live births: _________________

Number of pregnancies: __________________ Number of C-sections: _________________

Number of miscarriages: __________________ Number of children still living: __________

Patient Name:____

University of Maryland Upper Chesapeake Health

Upper Chesapeake Primary Care-Forest Hill

Family Health History: (please list medical conditions below)

Father: ____

Mother: ____

Brother: ____

Sister: ____

Other: ____

SOCIAL HISTORY

EMPLOYMENT STATUS PLEASE SELECT FROM BELOW	**EXERCISE** PLEASE SELECT FROM BELOW	**SPORTS** PLEASE SELECT FROM BELOW
Employed	Daily	Recreational
Retired	Weekly	School/College
Student	Monthly	Club
Unemployment	Rarely/Never	What Type?
Disabled	What Type?	
Occupation:		
Job Description:		
SMOKING STATUS PLEASE SELECT FROM BELOW	**ALCOHOL** PLEASE SELECT FROM BELOW	**SUBSTANCE ABUSE** PLEASE SELECT FROM BELOW
Never	Yes/No	Yes/No
Current	Daily, Weekly, Monthly, Yearly	If, yes please explain below
Former		
History of Smoking		
How long since you have quit?		

Patient Name:____

UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

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Patient Name:____