HUB CITY Family Practice LLC

19426 Leitersburg Pike
Hagerstown, MD 21742
Phone: 240-513-6330
Fax: 240-513-6332

NEW PATIENT SELF HISTORY FORM

Date this form was completed: ____ / _____ / _____

_____ _____ _____
Last Name First Name MI

Birthdate: _____/ _____/ _____ Age: _____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Employment:

☐ Full Time ☐ Part Time ☐ Unemployed ☐ Disabled ☐ Retired ☐ Student

Occupation (or previous occupation if retired): _____

CURRENT HEALTH CONCERNS (Please identify in the space below the purpose for this examination and any problems or current medical conditions that you wish to have evaluated at this time.) _____

_____

PAST / PRESENT MEDICAL HISTORY:

Please check any ongoing medical conditions for which you have already been diagnosed, including serious illnesses of the past. DO NOT check any problems that have not yet been addressed by a doctor.

☐ No Past/Present Medical History
☐ Acid Reflux (530.81)
☐ Alcoholism (305.00)
☐ Alzheimer's Disease (294.1)
☐ Anemia (285.9)
☐ Anxiety (300.00)
☐ Arthritis (715)
☐ Asthma (493)
☐ Atrial Fibrillation (427.31)
☐ Bipolar Disorder (296.40)
☐ Cancer Type:_____ Year: _____
☐ Carpal Tunnel Syndrome(354)
☐ Cataracts (366)
☐ Chronic Constipation (564.00)
☐ Chronic Pain - Where? _____
☐ Coronary Artery Disease (414.00)
☐ Degenerative Disc Disease (722.22)
☐ Depression (311)
☐ Diabetes Type I (250.1)
☐ Diabetes Type II (250.0)
☐ Drug Abuse (305.90)
☐ Eczema (692.9)
☐ Emphysema (492)
☐ Erectile Dysfunction (607.84)
☐ Fibromyalgia(729.1)
☐ Glaucoma (492)
☐ Hearing Loss (389.9)
☐ Heart Failure(Congestive) (428.0)
☐ Heart Attack (410) Year: _____
☐ Hemorrhoids (455)
☐ H. Pylori Infection
☐ High Blood Pressure (401.1)
☐ High Cholesterol (272.0)
☐ High Triglycerides (272.1)
☐ Irritable Bladder (596.59)
☐ Irritable Bowel Syndrome (564.1)
☐ Irregular/Heavy Menses
☐ Kidney Stones (274.11)
☐ Macular Degeneration (362.50)
☐ Migraine Headaches (346)
☐ Obesity (278.0)
☐ Panic Disorder (300.21)
☐ Premenstrual Concerns
☐ Prostate Enlargement (600)
☐ Rheumatoid Arthritis
☐ Seasonal Allergies (477.0)
☐ Seizure Disorder (345)
☐ Sleep Apnea (786.03)
☐ Stomach Ulcers (533.9)
☐ Stroke (434.91) Year _____
☐ Transient Ischemic Attack (435.9) _____ Year:_____
☐ Tension Headaches(784.00)
☐ Underactive Thyroid (244.9)
☐ Overactive Thyroid (240.0)
☐ Trauma/MVA/Broken Bones
☐ Other: _____

ALLERGIES:

Latex Allergy: ☐ No ☐ Yes (if yes, list reaction) _____
Other Allergies (i.e. Bees, food, shellfish – please list reaction)**:** _____

Drug Allergies: ☐ No ☐ Yes (if yes, list **drug** and type of **reaction** below)

_____ _____
_____ _____
_____ _____
_____ _____

PATIENT NAME: _____

IMMUNIZATIONS:

Have you received an Influenza Vaccine this year? ☐ No ☐ Yes (if yes, when did you receive it) Date:_____/_____/____

Have you ever received a Pneumonia Vaccine? ☐ No ☐ Yes (if yes, when did you receive your last one)

Date:_____/_____/____

When was your last Tetanus vaccine? _____ Was it a TDap (Pertussis)? ☐ No ☐ Yes

List any adverse vaccine reactions (if applicable): _____

FAMILY HISTORY:

Please check any medical conditions/diseases in your family. These should be serious illnesses of mother, father, or siblings. Please indicate beside the illness, **F=Father**, **M= Mother**, **B= Brother, S= Sister**

☐ No Known Family History
☐ Abdominal Aortic Aneurysm _____
☐ Alcoholism _____
☐ Alzheimer's Disease _____
☐ Arthritis _____
☐ Asthma _____
☐ Cancer (Breast) _____
☐ Cancer (Colon) _____
☐ Cancer (Lung) _____
☐ Cancer (Ovarian) _____
☐ Cancer (Prostate) _____
☐ Cataracts _____
☐ Cirrhosis _____
☐ Congenital Heart Disease _____
☐ Congestive Heart Failure _____
☐ Depression _____
☐ Diabetes _____
☐ Emphysema _____
☐ Glaucoma _____
☐ Gout _____
☐ Heart Disease _____
☐ Hemophilia (Bleeding Disorder) _____
☐ High Cholesterol _____
☐ Hypertension _____
☐ Kidney Failure _____
☐ Kidney Stones _____
☐ Migraine Headaches _____
☐ Osteoporosis _____
☐ Overactive Thyroid _____
☐ Parkinson's Disease _____
☐ Underactive Thyroid _____
☐ Unknown _____
☐ Vein Disorders _____
☐ Other_____
_____
_____

SOCIAL HISTORY:

Do you smoke or use tobacco products?				**Amount**	**Duration**
Cigarettes	☐ Never	☐ Currently	☐ Previously	_____	_____
Chews	☐ Never	☐ Currently	☐ Previously	_____	_____
Cigar	☐ Never	☐ Currently	☐ Previously	_____	_____
Pipe	☐ Never	☐ Currently	☐ Previously	_____	_____
Dip snuff	☐ Never	☐ Currently	☐ Previously	_____	_____

Have you ever used recreational drugs?

Marijuana	☐ Never	☐ Currently	☐ Previously
Heroin	☐ Never	☐ Currently	☐ Previously
Cocaine	☐ Never	☐ Currently	☐ Previously
Other: _____	☐ Never	☐ Currently	☐ Previously

Do family members smoke outside? ☐ No ☐ Yes

Do family members smoke inside? ☐ No ☐ Yes

Do you drink alcohol beverages? ☐ No ☐ Yes If so, how many drinks per week:_____

Do you follow any special diet? If yes, please identify: _____

How often do you get 30-60 minutes of aerobic exercise? _____daily _____x/week _____x/month

Do you have animals in your home? ☐ No ☐ Yes If yes, what type? _____

MEDICATIONS:

Please list all MEDICATIONS, their dosage, and other pills that you take including supplements and herbals:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

SURGICAL HISTORY:

Please list ANY surgeries you have had in your lifetime either outpatient or while hospitalized.

Date	Surgery	Location (Hospital, City)	Complication/Other Info

OTHER HOSPITALIZATIONS **(Please list any other hospitalizations including pregnancy, illness or other procedures)**

Date	Hospitalization Purpose	Location (Hospital, City)	Complication/Other Info

Pharmacies: (list your preferred pharmacy)		**Street Name**	**City, State**
Local Pharmacy Name:			
Mail Order Pharmacy Name:			

For Office Use Only:		
Weight: _____	Height: _____	BMI: _____

PATIENT NAME: _____

HUB CITY Family Practice

REVIEW OF SYSTEMS:

These questions pertain to CURRENT symptoms or problems you may be experiencing. Please check each one that is CURRENTLY a concern.

GENERAL ☐ None ☐ Fever ☐ Chills ☐ Night Sweats ☐ Weight Gain ☐ Unexplained Weight Loss ☐ Cold or hot all the time ☐ Fatigue ☐ Other _____	**SKIN** ☐ None ☐ Skin Rashes ☐ Itchy Skin ☐ Bruising ☐ New or changing moles ☐ Change in hair or nails ☐ Other: _____ _____	**EYES** ☐ None ☐ Headaches ☐ Change in vision ☐ Wears glasses/contacts ☐ Blindness ☐ Other: _____ _____	**EARS** ☐ None ☐ Hearing loss ☐ Ringing in ears ☐ Earaches ☐ Ear drainage ☐ Other: _____ _____
NOSE/MOUTH/THROAT ☐ None ☐ Nosebleeds ☐ Sinus problems or hay fever ☐ Hoarseness ☐ Problems with teeth or gums ☐ Voice Changes ☐ Other: _____	**NECK** ☐ None ☐ Swollen Glands ☐ Neck Mass ☐ Other: _____ _____	**RESPIRATORY** ☐ None ☐ Cough ☐ Shortness of Breath ☐ Wheezing ☐ Other: _____ _____	**CARDIOVASCULAR** ☐ None ☐ Irregular Heartbeats ☐ (palpitations) ☐ Chest Pains ☐ Blood Clots ☐ Swelling in ankles or feet ☐ Other: _____
GASTROINTESTINAL ☐ None ☐ Abdominal Pain ☐ Nausea ☐ Vomiting ☐ Reflux ☐ Constipation/Diarrhea ☐ Blood in stool ☐ Changes in bowel habit ☐ Other: _____ _____	**GENITOURINARY** ☐ None ☐ Urinating frequently ☐ Urinary pain/burning ☐ Blood in urine ☐ Leaking urine/ Incontinence ☐ Up at night to urinate ☐ Poor urinary stream ☐ Other: _____ _____	**SEXUAL HISTORY** ☐ None ☐ Having sex: □ Currently □ In past ☐ Total number of partners ___ ☐ Method of birth control ____ ☐ Age of first menses _____ ☐ Last menstrual period _____ ☐ Feel unsafe in relationship ☐ Sexual difficulties ☐ Erectile dysfunction ☐ STD/STI history: _____	**MUSCULOSKELETAL** ☐ None ☐ Joint pain, swelling, stiffness ☐ Muscle weakness ☐ Muscle pain, cramps ☐ Other: _____ _____
ENDOCRINE ☐ None ☐ Diabetes ☐ Thyroid Problems ☐ Excessive Urination ☐ Other: _____ _____	**NEUROLOGICAL** ☐ None ☐ Seizures ☐ Fainting ☐ Disorientation ☐ Headaches ☐ Other: _____ _____	**MENTAL HEALTH** ☐ None ☐ Anxiety ☐ Excessive Stress ☐ Panic Attacks ☐ Depression ☐ Other: _____ _____	**HEMATOLOGIC/ LYMPHATIC** ☐ None ☐ Swollen glands ☐ Easy bruising/bleeding ☐ History of blood transfusion ☐ Anemia ☐ Other: _____

THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE:

_____ _____/ _____/ _____

Patient / Guardian Signature (relationship to patient) or Power of Attorney Date

Print Name: _____

Reviewed by Hub City Family Practice: _____ _____/ _____/ _____

Date