Mary Washington Primary Care

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Patient Information

Name: _____
Last First Middle Initial Maiden

Date of Birth: ____ / ____ / ____
Month Day Year

Address: _____
Street APT#

Age: _____ Sex: ❑ F ❑ M

_____
City State Zip

Phone: (home) _____

(work) _____

Marital Status: _____

(cell) _____

Email Address: _____

SSN: _____

Employer Name and Address: _____

Preferred Method of Contact (Check one): ❑ Home ❑ Cell ❑ Work ❑ Email

Race (Check One): ❑ African American/Black ❑ American Indian/Alaskan Native ❑ Asian ❑ Caucasian/White ❑ Native Hawaiian/Pacific Islander ❑ Other ❑ Unknown ❑ Declined

Ethnicity (Check One): ❑ Hispanic/Latino ❑ Not Hispanic/Latino ❑ Unknown ❑ Declined

Preferred Pharmacy Name and Address: _____

Medical Insurance Information

Primary Carrier: _____ Contact Phone Number: _____

Claims Address: _____

Policy Holder/Subscriber Name: _____ Policy Holder's DOB: _____

Policy/Member ID Number: _____ Group Number: _____

Secondary Carrier: _____ Contact Phone Number: _____

Claims Address: _____

Policy Holder/Subscriber Name: _____ Policy Holder's DOB: _____

Policy/Member ID Number: _____ Group Number: _____

Guarantor/Legal Guardian Information (Only if Patient is a Minor)

Full Name: _____ Date of Birth: _____

Address: _____ Home Phone: _____

City, State, Zip Code: _____ Work Phone: _____

Gender: _____ Marital Status: _____ Cell Phone: _____

Email Address: _____ Employer: _____

Employer's Address: _____

Other Information

Emergency Contact: _____ Relationship to Patient: _____

Home Phone: _____ Work Phone: _____

How were you referred to our practice? _____

Mary Washington Primary Care
Adult Health History Questionnaire (ages 13 and up)

Patient Name: _____ DOB: _____ Date: _____

Nickname: _____ Sex: ❑ F ❑ M Age: _____

Personal Health History

Past Medical History and Family History – Please check all that may apply for you and/or family member

	You	Family Member and Who		You	Family Member and Who
Alcohol Abuse			Heart Disease		
Allergic Rhinitis			Hepatitis C Infection		
Alzheimer's Disease			Hyperlipidemia (cholesterol)		
Anemia (Iron Deficiency)			Hypertension		
Anxiety Disorder			Insomnia		
Arthritis (Osteoarthritis)			Irritable Bowel Syndrome (IBS)		
Arthritis (Rheumatoid)			Kidney Disease		
Asthma			Kidney Stones		
ADD / ADHD			Macular Degeneration		
Bipolar Disorder			Meningitis		
BPH (enlarged prostate)			Menopausal Synd.		
Cancer – Breast			Migraine/Headaches		
Cancer – Lung			Sleep Apnea		
Cancer – Prostate			Obesity		
Cancer – Colon			Osteoporosis		
Cancer – Other			Pacemaker		
COPD / Emphysema			Parkinson's Disease		
Coronary Artery Disease			Peripheral Vascular Disease		
Crohn's /Ulcerative Colitis			Post Gastric Bypass		
Deep Vein Thrombosis (DVT)			Pulmonary Embolism		
Depression			Rosacea		
Diabetes Mellitus, Type II			Seizure Disorder		
Diabetes Mellitus, Type I			Skin Disease		
Drug Abuse			Stroke ❑ TIA ("mini stroke")		
Emphysema			Thyroid d/o – hypothyroid		
Erectile Dysfunction			Thyroid d/o – hyperthyroid		
Fibromyalgia			Tobacco Abuse		
Gallstones			Tuberculosis		
Gastritis / Esophagitis			Other:		
GERD (reflux)			Other:		
Glaucoma			Other:		
Gout			Other:		
Hearing Loss (formal diagnosis)			Other:		
Heart Attack			Other:		

Past Surgeries & Hospitalizations

Month/Year	Surgery / Reason for Hospitalization	Which Hospital

Medications (including over-the-counter medications as well as herbal)

Medication Name	Strength	Frequency	Reason for Medication

Allergies (list any medical, food and/or environmental allergies)

Medication/Allergen	What was your reaction?	Medication/Allergen	What was your reaction?

Social History

Marital Status	❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Living Together	
Are you employed?	**If Yes, what is your profession?**	**Retired?** ❑ Yes ❑ No
Are you disabled?	❑ Yes ❑ No	
Highest level of education?	❑ Did not graduate HS ❑ High School / GED ❑ Some College ❑ College ❑ Post-Graduate	
Religious preference?		
Who lives at home?		
Have you been in the military?		**If so, ever stationed overseas?**

Health Habits and Safety:

Exercise & Weight	Current Weight:	Desired Weight:	Weight 1 Year Ago:
	Exercise Regularly? ❑ Yes ❑ No	What type:	How often:
	Do you follow a special diet? ❑ No ❑ Yes, explain:		
Sleep	How many hours do you sleep:		
Tobacco:	Do you currently use tobacco? ❑ No ❑ Cigarettes ❑ Cigars ❑ Pipes ❑ Chewing Tobacco		
	How many packs per day:	Age when you started tobacco:	
	Are you a former smoker who has quit? ❑ No ❑ Yes	When did you quit:	
	If a non-smoker, are you exposed to second hand smoke? ❑ No ❑ Yes		
Alcohol:	How much alcohol do you drink in 1 week:		
	What do you drink?:		
	Are you concerned about how much you drink? ❑ Yes ❑ No	Have others expressed concern? ❑ Yes ❑ No	
Drugs	Do you currently use any recreational / street drugs? ❑ No ❑ Yes. If so, What drug:		
	Do you currently, or have you ever, used drugs through a needle (IV drug use): ❑ No ❑ Yes		
	Do you feel you have a drug problem? ❑ Yes ❑ No		
Safety:	Do you feel safe at home? ❑ Yes ❑ No		
	Do you always wear a seat belt? ❑ Yes ❑ No		
	Is there a firearm in your home? ❑ Yes ❑ No	If yes, is it secured from children? ❑ Yes ❑ No	

Health Maintenance

Men & Women:

When was your last PHYSICAL:	**When was your last CHOLESTEROL check:**
When was your last COLONOSCOPY:	**When was your last BONE DENSITY**
When was your last PNEUMONIA VACCINE:	**Do you get FLU SHOTS:** ❑ Yes ❑ No
Have you had Hepatitis B Vaccine: ❑ Yes ❑ No	**When was your last TETANUS (Td or TDaP):**
What birth control do you use:	**What sexually transmitted diseases have you had:**

Women Only & Reproductive Health:

Age when periods started:	**Are your periods regular?** ❑ Yes ❑ No
How many days apart:	**How many days do your periods last:**
How is your flow? ❑ Light ❑ Medium ❑ Heavy	**How is your cramping?** ❑ Mild ❑ Moderate ❑ Severe
When was your last **Pap Smear:**	**What were the pap results?** ❑ Normal ❑ Abnormal
When was your last **Mammogram:**	**Do you do monthly self-breast exams?** ❑ Yes ❑ No

Total Pregnancies:	Full Term:	Premature:	Miscarriages:	Abortions

Men Only & Reproductive Health:

Do you have problems with impotence? ❑ Yes ❑ No	**Are there any sexual concerns:** ❑ Yes ❑ No
Do you have a prostate problem? ❑ Yes ❑ No	**Do you perform self-testicular exams?** ❑ Yes ❑ No
How many children do you have personally?	

Care Team (your specialists)

Specialist:	**Their specialty**	**Specialist**	**Their Specialty**

Patient Signature: _____

Parent/Guardian Name (if patient is under 18 years): _____

Parent/Guardian Signature: _____

Relationship to Patient: _____