GREATER HAMPSTEAD FAMILY MEDICINE, P.C.

Today's Date: _______________

Name (Last, First, MI):_______________________________ Date of Birth:____________

Why are you seeing the doctor today? _________________________________

Are you on any Medications that are Prescribed by another Physician:

Medication	Dose	Reason for Medication

Have you been diagnosed with any Medical Conditions in the last year? ___ No ___ **Yes**: __________
Have you developed any new Allergies in the last year? ___ No ___ **Yes**: ___________________

Have you had any Surgeries in the last year?

Surgeries/Hospitalizations	Date	Complications/Problems with anesthesia

Have you had any Deaths in the Family in the last year? ___ No ___ **Yes**: ___________________
Have you started Smoking or Quit Smoking in the last year? ___ Started ___ Quit

Do you consume alcohol? ____ YES ____ NO
How often (Times a week)? ____________________
How many drinks? ____________________
Have you consumed 6 or more drinks? ____ YES ____ NO

Change in Marital Status: ___ No ___ **Yes** Status: _____________
Change in Living Status? __No __**Yes**
Occupation: ___________________ Retired: ________

REVIEW OF SYSTEMS

Are you currently having or have you had problems with: (Check all that apply)

__Eyes, __Ears, __Nose, __Throat, __Lungs, __Breathing, __Digestion/Bowels, __Bladder,

__Bleeding, __Skin/Rashes, __Lesions, __Muscles, __Numbness/Tingling, __Arthritis/Joint,

__Psychological, __Chest Pain, __Irregular Heartbeat, __Infectious Diseases

____________________________________ ____________________________

Patient/Guardians Signature Date

____________________________________ ____________________________

Physician's Signature Date