CENTENNIAL MEDICAL GROUP
8186 Lark Brown Road Elkridge MD 21075
10981 Johns Hopkins Road Laurel MD 20723
(410) 730-3399
FirstCall URGENT CARE DOCTORS ALWAYS ON CALL

NAME: DOB: MRN:

DATE: PROVIDER:

Centennial Medical Group

Patient Questionnaire

The following information is very important to your health. Please take time to fully and completely fill out this important information. Use an "x" when making selections. We are counting on you. **Please PRINT all information other than signature.**

Patient Medical History

What are your current concerns about your health?

_____

Please place an "x" in the space if you have had any of these medical problems in the past:

_____ stroke/TIA	_____ substance abuse	_____ psychiatric disease	_____ glaucoma
_____ migraines	_____ seizures	_____ chronic sinusitis	_____ hypertension
_____ heart disease	_____ heart valve disease	_____ murmur	_____ asthma
_____ tuberculosis	_____ elevated cholesterol	_____ COPD/Emphysema	_____ pneumonia
_____ GERD	_____ peptic ulcer disease	_____ irritable bowel	_____ hepatitis
_____ anemia	_____ gallbladder disease	_____ arthritis	_____ osteoporosis
_____ cancer	_____ prostate problems	_____ kidney stones	_____ diabetes
_____ skin disease	_____ DVT/blood clots	_____ thyroid disease	_____ herpes
_____ syphilis	_____ gonorrhea	_____ abnormal pap smear	_____ HIV

Other:_____

Last Menstrual Period: _____

PREVIOUS HOSPITALIZATIONS: (Please list date and reason) _____ None

_____

_____

_____

PAST SURGICAL HISTORY: (Please list if you have had any surgery) _____ None

____ appendectomy	____ hysterectomy	____ tonsillectomy	____ cholecystectomy
____ hernia repair	____ sinus surgery	____ vasectomy	____ tubal ligation
____ cataract surgery	____ Other: _____		

IMMUNIZATIONS:

Please list the dates of your most recent immunizations / conditions:

Tetanus _____ MMR#1 _____ MMR#2 _____ Polio _____

Hepatitis B series completed _____ Influenza vaccine _____ Pneumonia _____

Hepatitis A series completed _____ Chickenpox vaccine or illness _____

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Please list the dates of any of the following procedures that you have had performed:

Rectal examination _____
Bone density _____
EKG _____
Stress test _____
Mammogram _____
Cholesterol level _____
Chest x-ray _____
Eye exam _____
Colonoscopy _____
PSA _____
Pap smear _____

HABITS/SOCIAL:

What type of work do you do: _____
Employer: _____
Have you been exposed to any toxin (i.e. asbestos, lead, pesticides…)? _____ Y _____ N
Do you smoke cigarettes? _____ Y _____ N How much? _____
Do you chew tobacco? _____ Y _____ N How much? _____
How many alcoholic drinks to you have in one week? _____
How many caffeinated beverages (including colas) do you consume daily? _____
Do you watch your diet to restrict slat, fat or meat? _____ Y _____ N
Do you do regular aerobic exercise? _____ Y _____ N How many times a week? _____
Do you have trouble falling asleep? _____ Y _____ N
Do you have trouble staying asleep? _____ Y _____ N
Do you feel rested in the morning? _____ Y _____ N
Do you wake up earlier in the morning than you should? _____ Y _____ N
Do you experience daytime drowsiness? _____ Y _____ N
Do you use seatbelts while driving? _____ Y _____ N
What is your marital status? _____ S _____ M _____ D _____ W
How many children do you have? _____
Are you sexually active? _____ Y _____ N
What do you use for birth control? _____
Have you ever received a blood transfusion? _____ Y _____ N
Have you recently found less interest / pleasure in doing things? _____ Y _____ N
Have you recently felt down, depressed or hopeless? _____ Y _____ N

FAMILY HISTORY: Place an "x" next to all of those conditions your family members have experienced:

_____ hypertension _____ heart disease _____ diabetes mellitus _____ high cholesterol
_____ asthma _____ arthritis _____ glaucoma _____ cancer _____thyroid problems
_____ osteoporosis _____ gout
Others: _____

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REVIEW OF SYSTEMS: Place an "x" if you have had any of these symptoms recently

_____ fatigue _____ fever _____ chills _____ sweats _____ snoring _____ nosebleeds
_____ recent weight change _____ difficulty sleeping _____ itching eyes _____ cough
_____ discharge from eyes _____ redness in your eyes _____ change in vision
_____ changes in hearing _____ ringing in your ears _____ nasal congestion _____ hoarseness
_____ frequent sore throat _____ dental problems _____ shortness of breath _____ wheezing
_____ coughing up blood _____ chest pain or pressure with exertion _____ palpitations
_____ edema / fluid retention _____ difficulty breathing when lying flat _____ nausea
_____ vomiting _____ diarrhea _____ constipation _____ trouble swallowing _____ jaundice
_____ changes in bowel habits _____ abdominal pain _____ blood in stool
_____ difficulty urinating _____ pain with urination _____ blood in urine _____ increased urination
_____ increased frequency of urination _____ waking up to urinate at night
_____ muscle pain _____ muscle weakness _____ joint pain _____ limited movement of joints
_____ itching _____ changes in moles _____ rash _____ cold extremities _____ headaches
_____ numbness _____ "pins and needles" _____ problems with balance _____tremor
_____ anxiety _____ suicidal thoughts _____ changes in mood _____ increased thirst
_____ increased urination _____ heat or cold intolerance _____ easy bruising _____ hives
_____ abnormal bleeding _____ lymph node swelling _____ seasonal runny nose

Known Allergies: _____

All current medications:

_____

_____

_____

_____

_____

_____

_____

My signature below indicates this information is true and correct to the best of my belief.

Patient's Signature: _____