1ST MEDICAL OF ANNAPOLIS

NEW PATIENT FORM

Patient Name: _____, _____ ____.
(Last) (First) (M.I.)

D.O.B.:__ __/__ __/__ __ __ __ **Date:** ___ ___/___ ___/ **Time:** __ __ : __ __ am pm

Reason for visit today:

_____

_____.

Review of Systems: (circle all that apply).

CONSTITUTIONAL: weight loss, night sweats, loss of appetite, fever, fatigue
EYES: eye pain,blurry vision
EAR, NOSE,THROAT: difficult hearing, ringing in ears,dizziness,nasal congestion,sore throat
CARDIOVASCULAR; chest pain,palpitations,fainting spells,swollen ankles,short ness of breath
RESPIRATORY:cough,coughing up blood,wheezing,chills,fever
ENDOCRINE: excessive hair loss,heat/cold tolerance intolerance,tiredness
GASTROINTESTINAL: heartburn,nausea,vomiting,diarrhea,constipation,pain,black/bloody stools
GENITOURINARY: burning,frequency,blood in the urine,abnormal discharge,bladder leakage, urgency
ALLERGIC/IMMUNOLOGIC:hives,eczema,hayfever
PSYCHIATRIC; anxiety,depression,mood swings,difficult sleeping,medications for brain health
HEMATOLOGY:blood disorder,bruising,enlarged glands, gum or nose bleed,anemia,transfusions
MUSCULOSKELETAL:joint pain/swelling,joint stiffness,muscle pain, back pain
SKIN; rash,sores,new skin lesions,new skin rash
NEUROLOGICAL; loss of strength,numbness,headache pain,tremors,memory loss

Past Medical History:

Past surgical history: _____.

Social History: Occupation _____marital status S M D W

Alcohol use: Never/social/regular Cigarette smoking: NO YES packs/day

Family History: _____.

Current Medications: _____.

Drug Allergies: _____.

Name,location & phone# of your pharmacy

Is this visit the result of a car accident? Y N Is this Worker's Compensation Y N

I have read and accept the HIPPA agreement; Y N Notice of Privacy practices: Y N

I consent to treatment for myself or above minor child. I understand that I am responsible for all charges for medical services provided by 1st Medical of Annapolis. I do hereby authorize the release of medical information necessary for the processing of claims pursuant to services provided.

Patient Signature: Date: