True Physician Care, LLC
10215 Fernwood Road, Suite 405
Bethesda, Maryland 20817

MEDICAL HISTORY

_____ _____ _____

Today's Date Name Date of Birth

Allergies to medication: _____

Past Medical History

Major Illnesses/Hospitalizations: (list, date): _____

_____

Accidents/Injuries (list, date): _____

_____

Chronic conditions: (List specialists you see on a regular basis): _____

_____

_____

_____

Current Medications and Dosages Including Over-The-Counter Medications

_____

_____

_____

_____

Family History [list significant medical problems]

Father (Living/Deceased, Age____): _____

Mother (Living/Deceased, Age ___): _____

Siblings: _____

List any other relatives who have had any of the following:

High blood pressure	High cholesterol	Heart disease
Stroke	Diabetes	Thyroid disease
Cancer	Blood clot/DVT	Osteoporosis
Depression/Mood disorder	Kidney disease	Migraines
Alcoholism/Substance abuse	Asthma	Other: _____

Social History/Habits

Highest level of education: _____ Occupation: _____

Who lives in your home: _____

Gender Identity (please note if different from sex assigned at birth): _____

Marital status: _____ Sexual Orientation: _____

Sexually active: _____ Condom use/Safe sex: _____ Contraception: _____

History of sexually transmitted infection: _____

Have you ever felt unsafe in a relationship or at home:_____

Current or prior tobacco use (years, type, quantity): _____

Current or prior alcohol use: _____ drinks per week

Current or prior drug use (type, frequency): _____

Diet (any special restrictions): _____

Exercise: Type of exercise _____ Hours per week _____

Significant travel or places outside the U.S. you have previously resided: _____

Preventative [list approximate date, if applicable]

Last tetanus shot	_____	Last pneumococcal vaccine	_____
Colonoscopy	_____	Mammogram	_____
Bone density (DEXA)	_____	Pap smear	_____

Gynecological History

Age menses began: _____ Menses every _____ days # of days of bleeding: _____ Date of last menses: _____

Number of - Pregnancies: _____ Deliveries: _____ Abortions (spontaneous or induced): _____

Reviewed by Physician: _____ Date: _____