CALVERT
INTERNAL MEDICINE
Group

Name____ Date of Birth___________________
Primary Care Physician ____
The following information will assist us in providing you the most excellent care. **Please fill out completely.**

MEDICAL HISTORY: (High Blood Pressure, Diabetes, Asthma, Cancer, Heart Disease, etc)

_______________________ _______________________ _______________________

_______________________ _______________________ _______________________

_______________________ _______________________ _______________________

_______________________ _______________________ _______________________

SURGICAL HISTORY: ☐ Check if NONE

_______________________ _______________________ _______________________

_______________________ _______________________ _______________________

ALLERGIES to medications: ☐ Check if NONE (If yes, please list medications and explain reaction

_______________________ ____

_______________________ ____

CURRENT PRESCRIPTION MEDICATIONS:
Name/ mg dose / # tablets, # per day
(Written List OK)

OTC MEDICATIONS
(Aspirin, Tylenol, Vitamins, etc)

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

FAMILY HISTORY (Medical Illnesses and Surgeries)
Mother: ____

Father: ____

Brother/Sisters: ____

Children: ____

SOCIAL HISTORY:
Smoke? ☐ Yes ☐ No If yes, how much ______# packs/day _______# years

ALCOHOL ☐ Yes ☐ No If yes, how much? ______________________________________

Family History of Cancer?
Relation: _________________ Type: _________________ Age of diagnosis: _______________

Relation: _________________ Type: _________________ Age of diagnosis: _______________

Last Tetanus Shot:_______________ Last Flu Vaccine:______________ Last Pneumonia Vaccine:_______________

Last Colonoscopy:_______________ Last Mammogram:____________ Last Pap Screening:____________________

Last Done Density:______________