Parkway Medical Association
Medical History & Prevention Health Questionnaire

Name: ____________________________ Birth Date: ______________________________

Do you now or have you ever had any of the following:

- Diabetes
- High Blood pressure
- High cholesterol
- Anemia
- Thyroid Issues
- Asthma
- COPD
- Hepatitis
- Stroke
- Seizures
- Acid Reflux
- Vertigo
- Depression
- Anxiety
- Arthritis
- Kidney disease
- Heart disease
- Headaches/Migraines
- Cancer:_____________________
- Other:______________________

Are you allergic to any of the following: None ______

- Aspirin
- Penicillin
- Codeine
- Local Anesthetics
- Latex
- Sulfa Drugs
- Other:______________________

Smoker? No_____ Yes_____ Number of packs per day _____ Former smoker? _____
Alcohol? No_____ Yes_____ How much/often?_________________________________
Drugs? No_____ Yes_____ How much/often?_________________________________

Family History Medical History: None: _____

- Heart disease
- High Blood pressure
- High Cholesterol
- Diabetes
- Stroke
- Obesity
- Cancer:_____________________
- Other: ______________________

Current Medications with dosage

1). ____ 6). ____
2). ____ 7). ____
3). ____ 8). ____
4). ____ 9). ____
5). ____ 10). ____

Pharmacy:____

Past Surgeries

1). ____ 6). ____
2). ____ 7). ____
3). ____ 8). ____
4). ____ 9). ____
5). ____ 10). ____

Any problems with anesthesia? NO________ YES _________ (Please describe)___________________
____

MARRIED ______SEPERATED ______ SINGLE ______ WIDOWED ______DIVORCED ________

Comments:____
____
____
____
____
____

Parkway Medical Association
1600 S Crain Highway Ste. 201 Glen Burnie MD 21061

Acknowledgement of financial policy:

I acknowledge that I will be responsible for any copays and deductibles, or non-covered services. I agree to pay the copay at the time of service.

Signature:___________________________________Date:_______________________________

Authorization of Pay Benefits to Physician:
I authorize the release of medical or other information necessary to process health insurance claims
Authorization to Release Medical Information. I hereby authorize my Provider, Parkway Medical Association to release any information necessary for my course of treatment.

Signature: ____________________________________ Date:_____________________________

Acknowledgement of privacy practices:
I acknowledge that I have received the notice of privacy practice and I have been provided with an opportunity to review it.

Name: _______________________________________Date:_____________________________

Signature: ____

Release of Medical records:

List people our office is authorized to release your medical information to: (Ex: Spouse, Family)
1).____
2).____
3). ____

Emergency Contacts:

1). _____________________________________ Phone: _______________________________
2). _____________________________________ Phone: _______________________________
3). _____________________________________ Phone: _______________________________