MEDICAL HISTORY
REVIEW OF SYSTEM FORM

DATE:_____ NAME:_____ DATE OF BIRTH_____
___MARRIED ___SINGLE ___DIVORCED ___WIDOWED; OCCUPATION:_____
NO.OF CHILDREN:___ TOBACCO USE: YES/NO HOW MUCH?_____/DAY HOW LONG? DATE QUIT_____
ALCOHOL USE: HOW MUCH PER DAY?_____ CAFFEINE (COFFEE,TEA,COLAS) PER DAY_____

PAST ILLNESSES OF YOURSELF AND FAMILY:

YOU/YOUR FAMILY	YOU/YOUR FAMILY	YOU/YOUR FAMILY
☐ ☐ ALCOHOLISM	☐ ☐ HIGH BLOOD PRESSURE	☐ ☐ STROKE
☐ ☐ ANEMIA	☐ ☐ KIDNEY DISEASE	☐ ☐ SUICIDE ATTEMPT
☐ ☐ ASTHMA	☐ ☐ LIVER DISEASE	☐ ☐ THYROID DISEASE
☐ ☐ CANCER/TUMOR	☐ ☐ HEPATITIS	☐ ☐ TUBERCULOSIS, TB
☐ ☐ DIABETES	☐ ☐ LUNG DISEASE	☐ ☐ ULCER IN GI TRACT
☐ ☐ DRUG ABUSE	☐ ☐ MENTAL ILLNESS	☐ ☐ VENEREAL DISEASE
☐ ☐ DEPRESSION	☐ ☐ OSTEOARTHRITIS	☐ ☐ HIGH CHOLESTEROL
☐ ☐ EPILEPSY/SEIZURES	☐ ☐ OSTEOPOROSIS	☐ ☐ HIV/IMMUNE DX
☐ ☐ GLAUCOMA	☐ ☐ PHLEBITIS	☐ ☐ OTHER_____
☐ ☐ HEART DISEASE	☐ ☐ RHEUMATIC ARTHRITIS	

PAST SURGICAL HISTORY: (PLEASE INCLUDE DATES)

_____
_____
_____

REVIEW OF SYSTEMS-PLEASE CHECK EACH ITEM "YES" OR "NO" AS THEY RELATE TO YOUR HEALTH:

CONSTITUTIONAL:	Yes	No
Weight Loss	☐	☐
Fatigue	☐	☐
Fever	☐	☐
EYES:		
Glasses/Contacts	☐	☐
Eye Pain	☐	☐
Double Vision	☐	☐
Cataracts	☐	☐
EAR,NOSE,THROAT:		
Difficulty Hearing	☐	☐
Ringing in Ears	☐	☐
Vertigo	☐	☐
Sinus Trouble	☐	☐
Nasal Stuffiness	☐	☐
Frequent Sore Throat	☐	☐
CARDIOVASCULAR:		
Murmur	☐	☐
Chest Pain	☐	☐
Palpitations	☐	☐
Dizziness	☐	☐
Fainting Spells	☐	☐
Shortness of Breath	☐	☐
Difficulty lying Flat	☐	☐
Swelling Ankles	☐	☐
ENDOCRINE:		
Loss of Hair	☐	☐
Heat/Cold Intolerance	☐	☐

RESPIRATORY	Yes	No
Cough	☐	☐
Coughing Blood	☐	☐
Wheezing	☐	☐
Chills	☐	☐
GASTROINTESTINAL:		
Heartburn/Reflux	☐	☐
Nausea/Vomiting	☐	☐
Constipation	☐	☐
Change in BMs	☐	☐
Diarrhea	☐	☐
Jaundice	☐	☐
Abdominal Pain	☐	☐
Black or Bloody BM	☐	☐
GENITOURINARY:		
Burning/Frequency	☐	☐
Nighttime	☐	☐
Blood in Urine	☐	☐
Erectile Dysfunction	☐	☐
Abnormal Discharge	☐	☐
Bladder Leakage	☐	☐
ALLERGIC/IMMUNOLOGIC:		
Hives/Eczema	☐	☐
Hay Fever	☐	☐
PSYCHIATRIC:		
Anxiety/Depression	☐	☐
Mood Swings	☐	☐
Difficult Sleeping	☐	☐

HEMATOLOGY/LYMPH	Yes	No
Easy Bruising	☐	☐
Gums Bleed Easily	☐	☐
Enlarged Glands	☐	☐
MUSCULOSKELETAL:		
Joint Pain/Swelling	☐	☐
Stiffness	☐	☐
Muscle Pain	☐	☐
Back Pain	☐	☐
SKIN:		
Rash/Sores	☐	☐
Lesions	☐	☐
Itching/Burning	☐	☐
NEUROLOGICAL:		
Loss of Strength	☐	☐
Numbness	☐	☐
Headaches	☐	☐
Tremors	☐	☐
Memory Loss	☐	☐

FEMALES ONLY:
Date Last Mammogram_____
Normal____Abnormal_____
Date last PAP_____
Normal____Abnormal_____
Age Onset Periods_____
Age Onset Menopause_____
Periods Regular? Yes____No____
Number Pregnancies_____

SIGNATURE/REVIEWING PHYSICIAN_____

Phone number:

Email address:

NEW PATIENT- PLEASE COMPLETE THE FOLLOWING

Name:_____ Date:_____

CURRENT MEDICATIONS: INCLUDE BIRTH CONTROL PILLS, VITAMINS, AND SUPPLIMENTS

MEDICINE NAME	HOW TAKEN?	WHO PRESCRIBES?	NEED RX
			YES/NO
			YES/NO
			YES/NO
			YES/NO
			YES/NO
			YES/NO
			YES/NO

PREFERRED PHARMACY:_____ LOCATION:_____

PREVIOUS HEALTH CARE PROVIDERS IN PAST FIVE YEARS:

NAME	CITY/STATE	PROBLEM CARED FOR:	STILL SEEING?	REFERRAL?
			YES/NO	YES/NO
			YES/NO	YES/NO
			YES/NO	YES/NO
			YES/NO	YES/NO

ALLERGIC AND ADVERSE REACTIONS TO MEDICATIONS

NAME OF MEDICATION:	ADVERSE REACTION

ADDITIONAL INFORMATION:

LAST MAMMOGRAM?_____ WHERE?_____ LAST PAP?_____ GYN?_____

DR ARCENAS TO PERFORM FUTURE PAPS? YES_____ NO:_____

LAST COLONOSCOPY?_____ NORMAL?_____ DR?_____ REPEAT DATE?_____

APPROXIMATE DATE OF LAST BLOODWORK?_____ RECTAL EXAM?_____

VACCINE DATES:

TETANUS?_____ PNEUMONIA?_____ FLU?_____ HEPATITIS B SERIES?_____

MMCC ID #:

410 Family Medicine

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **[410 Family Medicine]** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **[410 Family Medicine]** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **[410 Family Medicine]** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **[Brandon Burr FNP-C]**.

With this consent, **[410 Family Medicine]** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **[410 Family Medicine]** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **[410 Family Medicine]** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **[410 Family Medicine]** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **[410 Family Medicine]** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **[410 Family Medicine]** may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable

MARYLAND MEDICAL CANNABIS
WAIVER AND RELEASE OF LIABILITY

In consideration of the risk of injury while participating in the Activity of MARYLAND MEDICAL CANNABIS use, and as consideration for the right to participate in the Activity of MARYLAND MEDICAL CANNABIS use, I hereby, for myself, my heirs, executors, administrators, assigns, or personal representatives, knowingly and voluntarily enter into this waiver and release of liability and hereby waive any and all rights, claims or causes of action of any kind whatsoever arising out of my participation in the Activity of MARYLAND MEDICAL CANNABIS, and do hereby release and forever discharge EEHIM, INC dba, 410 Family Medicine, located at 11022 Nicholas Lane, Suite 2, Ocean Pines, Maryland, 21811. Their affiliates, medical managers, medical providers, agents, attorneys, staff, volunteers, heirs, representatives, predecessors, successors and assigns, for any physical or psychological injury, including but not limited to illness, paralysis, death, damages, economical or emotional loss, that I may suffer as a direct result of my participation in the aforementioned Activity, including traveling to and from an event related to this Activity.

I AM VOLUNTARILY PARTICIPATING IN THE AFOREMENTIONED ACTIVITY AND I AM PARTICIPATING IN THE ACTIVITY ENTIRELY AT MY OWN RISK. I AM AWARE OF THE RISKS ASSOCIATED WITH TRAVELING TO AND FROM AS WELL AS PARTICIPATING IN THIS ACTIVITY, WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO, PHYSICAL OR PSYCHOLOGICAL INJURY, PAIN, SUFFERING, ILLNESS, DISFIGUREMENT, TEMPORARY OR PERMANENT DISABILITY (INCLUDING PARALYSIS), ECONOMIC OR EMOTIONAL LOSS, AND DEATH. I UNDERSTAND THAT THESE INJURIES OR OUTCOMES MAY ARISE FROM MY OWN OR OTHERS' NEGLIGENCE, CONDITIONS RELATED TO TRAVEL, OR THE CONDITION OF THE ACTIVITY LOCATION(S). NONETHELESS, I ASSUME ALL RELATED RISKS, BOTH KNOWN OR UNKNOWN TO ME, OF MY PARTICIPATION IN THIS ACTIVITY, INCLUDING TRAVEL TO, FROM AND DURING THIS ACTIVITY.

I agree to indemnify and hold harmless against any and all claims, suits or actions of any kind whatsoever for liability, damages, compensation or otherwise brought by me or anyone on my behalf, including attorney's fees and any related costs, if litigation arises pursuant to any claims made by me or by anyone else acting on my behalf. If incurs any of these types of expenses, I agree to reimburse 410 Family Medicine all expenses.

I acknowledge that and their directors, officers, volunteers, representatives and agents are not responsible for errors, omissions, acts or failures to act of any party or entity conducting a specific event or activity on behalf of 410 Family Medicine. I acknowledge that this Activity may involve a test of a person's physical and mental limits and may carry with it the potential for death, serious injury, and property loss. The risks may include, but are not limited to, those caused by terrain, facilities, temperature, weather, lack of hydration, condition of participants, equipment, vehicular traffic and actions of others, including but not limited to, participants, volunteers, spectators, coaches, event officials and event monitors, and/or producers of the event.

I ACKNOWLEDGE THAT I HAVE CAREFULLY READ THIS "WAIVER AND RELEASE" AND FULLY UNDERSTAND THAT IT IS A RELEASE OF LIABILITY. I EXPRESSLY AGREE TO RELEASE AND DISCHARGE AND ALL OF ITS AFFILIATES, MANAGERS, MEMBERS, AGENTS, ATTORNEYS, STAFF, VOLUNTEERS, HEIRS, REPRESENTATIVES, PREDECESSORS, SUCCESSORS ND ASSIGNS, FROM ANY AND ALL CLAIMS OR CAUSES OF ACTION AND I AGREE TO VOLUNTARILY GIVE UP OR WAIVE ANY RIGHT THAT I OTHERWISE HAVE TO BRING A LEGAL ACTION AGAINST FOR PERSONAL INJURY OR PROPERTY DAMAGE.

To the extent that statute or case law does not prohibit releases for negligence, this release is also for negligence on the part of its agents, and employees. In the event that I should require medical care or treatment, I agree to be financially responsible for any costs incurred as a result of such treatment. I am aware and understand that I should carry my own health insurance.

In the event that any damage to equipment or facilities occurs as a result of my or my family's willful actions, neglect or recklessness, I acknowledge and agree to be held liable for any and all costs associated with any actions of neglect or recklessness.

Patient Signature: _____

Print Patient Name: _____

Date: _____

COMPANY: _____

DOCTOR: _____ **DATE:** __/__/____

Name:
PAN:
Date:

Primary:
Secondary:
Record:

Diagnosis

Procedures

Subjective:

Objective

Assessment:

Plan:

Name:	D.O.B:
Site : _____	Visit Date: ____/____/20__ (d d m m m y y)
Pt_ID: _____	

Visit Type (circle one):	Screening	Visit 2	Visit 5
	Baseline	Visit 3	Completion Visit
	Visit 1	Visit 4	Date:

1. Time ___:___ ☐ am ☐ pm

2. Heart Rate _____bpm ☐ Not Done

3. Blood Pressure_____/_____ (systolic/diastolic) ☐ Not Done

3.a BP Position
- ☐ Sitting
- ☐ Supine
- ☐ Standing

4. Temperature _____ ☐ oF ☐ oC ☐ Not Done

5. Respiratory Rate _____/min ☐ Not Done

6. Weight _____ ☐ pounds ☐ kilograms ☐ Estimated? ☐ Not Done

7. Height _____ ☐ inches ☐ centimeters ☐ Estimated? ☐ Not Done