Virginia Physicians, Inc.

Today's Date: _____

Health Questionnaire

Name: _____ Date of Birth: _____ Gender: _____

Current Medications

Please include all prescription and over the counter medications and any vitamins/supplements you routinely take. You may also bring a separate list with this information and/or pill bottles.

Name	Dose	Frequency
Ex: aspirin	*81 mg*	*Once a day*

Past Medical History

Please list all current or past medical or mental health conditions/ illnesses.

_____

_____

_____

Please list any specialists or other healthcare providers you see.

Provider	Reason

Previous Primary Care Provider: _____

Please list any surgeries or hospitalizations.

_____

_____

Please list any allergies to medications, insect stings, foods, etc. and type of reaction.

_____

Do you follow a special diet or have dietary restrictions? Ex: low sodium, low carb/sugar, vegetarian

_____

Patient Name: _____

Please indicate when you received any of these vaccines. If completing this form for a child, please bring all vaccine records to the appointment.

Tetanus/Diphtheria	Shingrix (new shingles vaccine)
Tdap (Td with pertussis/whooping cough)	Pneumonia (Pneumovax 23 and/or Prevnar 13)
Other:	

Please indicate when you have had any of these routine screenings and the results.

Colonoscopy	*Women:*	*Men:*
Eye Exam	Pap	PSA
Dental Exam	Mammogram	
Hepatitis C	Bone Density	

Family History

Family Member	Living Y/N	Age	Health Problems and/or cause of death *Ex: cancer, heart attack, stroke, diabetes*
Father			
Mother			
Siblings			

Social History

Marital Status	Number of Children
Occupation	Caffeine Use (amount)
Alcohol Use (amount)	Exercise (amount)

Smoking Status

- ☐ Never
- ☐ Former Smoker #Cigarettes/day _____ for _____ years When Quit: _____
- ☐ Current Smoker #Cigarettes/day _____ for _____ years
- ☐ Other: _____

Other Related Medical Information

_____

_____

_____