Virginia Physicians, Inc.

Medical History Questionnaire

Today's Date: _____

Patient Information:	
Patient Name:	Date of Birth:

Current Medications: (Please include dose and frequency): Include all prescription, 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.	
Drug Allergies:	

Past Medical History: Please list all current or past medical conditions/illnesses.

Surgical History: Please include dates.

Social History:	
Occupation:	Exercise (amount):
Alcohol (amount):	Smoking Status (circle one): Never Former Smoker Current Smoker
Caffeine (amount including all coffee, tea and soda):	If current or former smoker: # of cigarettes/day _____ for ____ years

Family History:		
Mother:	Living, age _____	Medical Problems:_____
	If deceased , age at death _____	Cause of Death:_____
Father:	Living, age _____	Medical Problems:_____
	If deceased , age at death _____	Cause of Death:_____
Brothers:	Age _____	Medical Problems:_____
	Age _____	Medical Problems:_____
Sisters:	Age _____	Medical Problems:_____
	Age _____	Medical Problems:_____

Immunizations: Please indicate when your most recent immunizations were**.**	
Tetanus (Tdap/Td):	Shingles (Shingrix):
Measles/Mumps/Rubella:	Pneumovax:
Hepatitis A:	Prevnar:
Hepatitis B:	Meningitis:

Health Maintenance: Please indicate when you most recently had these routine screenings.	
Colonoscopy:	DEXA (Bone Density):
Eye Exam:	Mammogram:
Dental Exam:	Pap Smear:
PSA (Prostate Cancer Screening):	Other:

Specialists: Please list any other healthcare provers you see and why.	

_____

Patient Signature (or Authorized Patient Representative) *Date*