

Health History Questionnaire

Family Medicine Center

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NAME: _____

DATE OF BIRTH: _____

Please check all that apply:

PAST MEDICAL HISTORY:

Chronic / Current conditions
(Cancer, Heart, Kidney, Thyroid,
Diabetes, High blood pressure, High
cholesterol, Lung, Depression)

Surgeries / Operations

Type / Year: _____

Type/ Year: _____

Type/ Year: _____

Dietary History:

of meals daily: _____

Snacks: _____

Vegetarian: _____

Fast food: _____

Other: _____

Weight at 19: _____

Current weight: _____

Prior Tests / Year:

Mammogram: _____

Echocardiogram: _____

Chest X-Ray: _____

Stress test: _____

Colonoscopy: _____

Pap smear: _____

Bone density: _____

Sleep study: _____

Ultrasound / CT: _____

Other: _____

Hospitalizations:

Year: _____

Year: _____

Year: _____

Recent ER visits: _____

Pregnancy: _____

IMMUNIZATIONS

Pneumovax: _____

Tdap: _____

Flu (during season): _____

Zoster (if over 60): _____

Gardasil: _____

TB test (PPD): _____

Other: _____

ALLERGIES: None known or list:

SOCIAL AND PERSONAL HISTORY

Tobacco use? Y or N

Cigarettes (_____ per day
for _____ years)

Chewing? Y or N

E-cigarretes Y or N

Second-hand smoke? Y or N

Alcohol: Social or Daily

Beer: _____

Wine: _____

Mixed drinks: _____

Caffeine: Y or N

per day

Soda: _____

Coffee: _____

Tea: _____

Chocolate: _____

Exercise

Aerobic: _____ # hours/week

Strength: _____ # hours/week

Stretch: _____ # hours/week

Illegal drugs: _____

Highest education: _____

Travel outside USA: _____

Marital Status: Single / Married /
Widowed Separated / Divorced

Partner / Spouse name: _____

Number of children: _____

Occupation: _____

Hobbies / Interests: _____

Driving concerns: _____

Do you wear seatbelts? _____

Talk on mobile or text while driving?

DISABILITY:

Mental: _____

Physical: _____

FAMILY MEMBER WITH:

Cancer: _____

Heart disease: _____

Early deaths: _____

Genetic disease: _____

Hypertension: _____

Thyroid: _____

Diabetes: _____

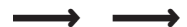
High Cholesterol: _____

Alcoholism: _____

Osteoporosis: _____

Other: _____

PLEASE TURN OVER PAGE



DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS:

CONSTITUTIONAL:

- Fever
- General pain
- Unexplained weight loss or gain
- Chills
- Fatigue

HEAD RELATED:

- Headache
- Sinus Pain

EYE SYMPTOMS:

- Eyesight problems
- Foreign body sensation
- Dry eyes
- Pus drainage
- Cataract
- Glaucoma

EAR NOSE AND THROAT SYMPTOMS:

- Ear
- Nose
- Throat
- Throat pain

NECK SYMPTOMS:

- Stiffness
- Swollen glands

CARDIOVASCULAR SYMPTOMS:

- Palpitations (fast heart beat)
- Chest pain or discomfort

GASTROINTESTINAL:

- Abdominal pain
- Blood in stool
- Black or tarry stool
- Nausea
- Vomiting
- Diarrhea

Swelling / bloating

- Constipation
- Change in appetite
- Heartburn

GENITOURINARY:

- Dysuria (painful urination)
- Polyuria (increased urination)
- Urinary incontinence
- Nocturia (getting up at night to urinate)

(Men) Erectile problems

Other:

SKIN:

- Lesions
- Nails

BREAST:

- Nipple discharge
- Warmth
- Lumps

MUSCOSKELETAL SYMPTOMS:

NEUROLOGICAL SYMPTOMS:

- Dizziness
- Memory lapses or loss
- Sensory disturbances
- Poor coordination
- Frequently becoming lost
- Frequent questions about recent events
- Frequent falls while walking
- Spinning dizziness (vertigo)

PULMONARY:

- Cough
- Wheezing
- Shortness of breath

PSYCHOLOGICAL SYMPTOMS:

- Depression
- Anxiety
- Sleep problems, snoring, apnea

HEMATOLOGIC SYMPTOMS:

- Bruise easily
- Anemia

ENDOCRINE:

- Temperature intolerance
- Hot flashes
- Excessive hair loss
- Change in libido (sex drive)
- Women only:
Age at onset of menses: _____
Last period: _____
Age at onset of menopause: _____

CURRENT MEDICATIONS

- _____
- _____
- _____
- _____
- _____
- _____
- _____

CURRENT VITAMINS / SUPPLEMENTS / OTC PRODUCTS / HERBAL MEDICATIONS

- _____
- _____
- _____
- _____
- _____
- _____

OTHER PHYSICIANS / PROVIDERS THAT YOU SEE

- _____
- _____
- _____
- _____
- _____

WHAT HEALTH SCREENING DOES NOT PAY FOR:

If problems are identified during this screening procedure (in other words a problem that requires further testing or a prescription) this will be billed at an appropriate additional rate. Simple problems will incur a Level II charge. Complex and multiple problems a Level III, Level IV or Level V charge. For example, if prescriptions are written for blood pressure, diabetes, and cholesterol medication and you need an X-Ray for back pain you will be billed an office visit for Level IV in addition to the charge for screening that will be paid for by the insurance company. If you have knee pain or sinusitis and you want this addressed during your health screening, that would be an additional Level III charge. You will be responsible for any additional charges on the date of service, unless you choose to have the additional issue(s) treated on a subsequent visit.

SIGNATURE: _____

DATE: _____