5544 Greenwich Rd • Suite 200 • Virginia Beach, VA 23462
Telephone (757) 466-0089 • Fax (757) 466-8017

WELCOME TO OUR OFFICE

Name:____Today's Date:___________
First Middle Last

Gender: Male___ Female____ Date of birth:_____________________Age:____________

Home Address:____

City: ______________________________ State:_________ Zip:_____________________

Home Phone:( )_______________________ Cell Phone:( )_________________________

Occupation:_____________________________SSN:______________________________

Employer:____Time of employment_____

Employer Address:______________________________City, State, Zip:_________________

Work Phone:( )_____________________Email:________________________________

Referred By:____

In Case of emergency, contact:_________________________Relationship:______________

Home Phone:( )____________________ Work Phone:( )__________________

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PATIENT HEALTH HISTORY FORM

Patient Name:______________________________________ Date of Birth__________________

Gender: Male______ Female:______ Preferred Language________________________________

Marital Status: Single___ Married___ Divorced___ Widowed___

Race: American Indian/ Alaska Native___ Asian___ Black/African American___ Native Hawaiian or Other Pacific Islander___ White/ Caucasian___ Other___

Ethnicity: Hispanic or Latino______ Not Hispanic or Latino_____

Do you have children Yes___ No___ How many?_________

Do you live alone?_____________ Who lives with you_________________________________

Smoker: Current every day smoker_______ Current some days smoker____________

Former smoker____________ Never smoked_________________

Do you drink alcohol? No, Never____ No, but I use to_______ Rarely___________

Yes____ Daily_____ 1 or more time per week____ 1 or more times per month______

Are you at risk for HIV/AIDS (e.g. unprotected sex, drug use, previous blood transfusion)?

No_____ Yes____ (the physician will discuss with you during visit.)

Have you ever had problems with anesthia? Yes_____ No_____

Past Medical History

Please list any major illness and/or injuries. **Surgeries/ Hospitalizations**	**Year**	**Complications**

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Patient Name:_________________________________ Date of Birth:___________________

Current Medications

Allergies

Allergies to medications?	

Family History

Family Member	Alive	Deceased	Age	Health status or Cause of Death
Grandmother(maternal)	A	D		
Grandmother(Paternal)	A	D		
Grandfather(maternal)	A	D		
Grandfather(paternal)	A	D		
Mother	A	D		
Father	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

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Patient Name: ____ Date of Birth_______________

Review of Systems

Are you currently having, or have had problems with:

Constitutional		Circle One
Fever		Yes No
Weight Loss		Yes No
Excessive Fatigue		Yes No
Night Sweats		Yes No
Eyes		Yes No
Wear Glasses	Date of Last Exam___________	Yes No
Infections		Yes No
Glaucoma		Yes No
Cataracts		Yes No
Ear, Nose, Throat and Mouth		Yes No
Wear Hearing Aids	Circle: Left Right or Both	Yes No
Hearing Loss		
Ear Pain		Yes No
Ear Infections		Yes No
Ringing in Ear(s)		Yes No
Balance Disturbance		Yes No
Nosebleeds		Yes No
Nasal Congestion		Yes No
Nasal Drainage		Yes No
Inability to Smell		Yes No
Sinus Problems		Yes No
Sore Throats		
Mouth Sores		
Cardiovascular/ Vascular		Yes No
Chest Pain or Angina		Yes No
High Blood Pressure		Yes No
Irregular Pulse		Yes No
Heart Mumur		Yes No

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High Cholesterol	Yes No
Swelling in Feet or Hands	Yes No

Respiratory

Asthma	Yes No
Chronic Cough	Yes No
Emphysema	Yes No
Shortness of Breath	Yes No
Bronchitis	Yes No
Pneumonia	Yes No
Lung Cancer	Yes No
Bloody Sputum	Yes No
Date of last Chest X-ray	Yes No

Gastrointestinal

Indigestion or Pain With	Yes No
Eating	Yes No
Nausea	Yes No
Vomiting	Yes No
Blood In your Vomit	Yes No
Liver Disease	Yes No
Jaundice	Yes No
Abdominal Pain	Yes No
Change in Bowel Habits	Yes No
Ulcers or Gastritis	Yes No
Colon Cancer	

Genitourinary Yes No

Urinary Tract Infections	Yes No
Painful Urination	Yes No
Blood in your Urine	Yes No
Difficulty Starting or Stopping	Yes No
Stream	Yes No
Incontinence	Yes No
Kidney Stones	Yes No

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Prostate Cancer (males)	Yes No
Endometriosis(females)	Yes No
Uterine or Cervical Cancer	
Musculoskeletal	Yes No
Broken Bones	Yes No
Arm or Leg Weakness	Yes No
Back Pain	Yes No
Arm or Leg Pain	Yes No
Joint Pain or Swelling	Yes No
Arthritis	Yes No
Integumentary	
Skin Disease	Yes No
Skin Cancer	Yes No
Breast pain,	Yes No
Tenderness or Swelling	Yes No
Nipple Discharge(females)	Yes No
Date and Result of Last Mammogram	
Neurological	
Fainting Spells	Yes No
Seizures	Yes No
Problems w/ memory	Yes No
Disorientation	Yes No
Difficulty with speech	Yes No
Inability to concentrate	Yes No
Double or Blurred vision	Yes No
Face Weakness	Yes No
Coordination in Arm/ Legs	Yes No
Psychiatric	
Anxiety	Yes No
Depression	Yes No
Other Psychiatric Disorder/ Treatment	

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Endocrine

Diabetes		Yes No
Thyroid Disease		Yes No
Increased Appetite		Yes No
Excessive Thirst or		Yes No
Urination		Yes No
Hormone Problems		

Hematologic/Lymphatic

Anemia		Yes No
Hemophia		Yes No
Bleeding Tendencies		
Persistent Swollen		Yes No
Glands or Lymph		
Nodes		
Blood Transfusion	If yes, when? ___________	Yes No

Allergic/Immunology

Food Allergies		Yes No
Inhalant (nasal)		
Immunologic		Yes No
Disorders		
Allergies		Yes No

The above information is accurate to the best of my knowledge.

Patient Signature____ Date:______________

I have reviewed the above information with the patient

Physician name (Signature)____________________________________ Date:_______________

Physician Name:____

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

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Acknowledging receipt of the Notice of Privacy Practices with you signature does not imply agreement or disagreement with this policy, just receipt of said policy.

Signature____________________________________

Date:_______________________________________