

1625 N. George Mason Drive | Suite 435 | Arlington, VA 22205  
 703.717.4700 *tel* | 703.717.4701 *fax*

***Patron Information***

Please answer the following questions. It will help your physician to provide excellent care not only based on your health and medical history but also based on relevant information about your immediate family and other relatives. By completing this form you also acknowledge that you have been provided with a copy of Virginia Hospital Center's Privacy Notice and that you understand that the information you provide will only be used for treatment, payment and Hospital operations as described in the Notice and in accordance with applicable federal and state laws and regulations.

Referred by (if applicable): \_\_\_\_\_

Your Full Name: \_\_\_\_\_ Gender: F \_\_\_ M \_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Full Name of Spouse: \_\_\_\_\_

Are you employed?     Yes             No             Retired

If yes, what is your occupation? \_\_\_\_\_ Company Name: \_\_\_\_\_

Have you traveled outside of the USA and/or Canada in the past five years?    Yes    No

If yes, where? \_\_\_\_\_

**Family History**

	Living	Present age or age at death	Significant health problems or cause of death
Father	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Mother	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Spouse/Partner	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

			Significant health problems or cause of death
Brothers	Number living	_____	_____
	Number dead	_____	_____
Sisters	Number living	_____	_____
	Number dead	_____	_____
Children	Number living	_____	_____
	Number dead	_____	_____

Present marriage (years): \_\_\_\_\_ Previous Marriage (s) (years): \_\_\_\_\_

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**Personal Medical History:**

Please check illnesses that have occurred in any of your **blood** relatives:

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Stroke        | <input type="checkbox"/> Cancer         | <input type="checkbox"/> Diabetes        | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Nervous Disease | <input type="checkbox"/> Bleeding Tendencies |

Please check illnesses or conditions which you have had:

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Bleeding Tendencies | <input type="checkbox"/> Cancer                      | <input type="checkbox"/> Diabetes             |
| <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> HIV                 | <input type="checkbox"/> Heart Trouble               | <input type="checkbox"/> Hepatitis            |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Jaundice            | <input type="checkbox"/> Kidney Disease              | <input type="checkbox"/> Nervous Disorder     |
| <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> Rheumatic Fever     | <input type="checkbox"/> Stroke/TA                   | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Hypothyroidism      | <input type="checkbox"/> Sleep Apnea         | <input type="checkbox"/> Obesity                     | <input type="checkbox"/> Elevated Cholesterol |
| <input type="checkbox"/> Blood Clots         | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Reflux/Peptic Ulcer Disease |   |
| <input type="checkbox"/> Other: _____        |  |  |   |

What type of exercise or physical activities do you perform and how frequently?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Previous surgeries (please list procedure and year):

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Have you had any serious injuries, broken bones, etc.?  Yes  No

If yes, please list: \_\_\_\_\_

Have you ever had an allergic reaction to any medications?  Yes  No

If yes, list medications and describe reactions: \_\_\_\_\_

Have you ever had an allergic reaction to X-ray contrast dye?  Yes  No

If yes, please describe: \_\_\_\_\_

Have you ever had a latex allergy?  Yes  No

If yes, please describe: \_\_\_\_\_

Have you ever had a tape allergy?  Yes  No

If yes, please describe: \_\_\_\_\_

Tobacco use:  Never  Now  In the Past

How much each day? \_\_\_\_\_ For how many years? \_\_\_\_\_  
 When did you quit? \_\_\_\_\_

Alcohol use:  Never  Now  In the Past

How much each day? \_\_\_\_\_ For how many years? \_\_\_\_\_  
 When did you quit? \_\_\_\_\_

Recreational Drug Use:  Never  Now  In the Past

How much each day? \_\_\_\_\_ For how many years? \_\_\_\_\_  
 When did you quit? \_\_\_\_\_

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Please check the immunizations you have received:

- Tetanus/TB (recommended every 10 yrs) \_\_\_\_\_  Hepatitis A  Measles  German Measles (Rubella)  
(immunization date)
- Pneumoccal Pneumonia (recommended every 6 yrs) \_\_\_\_\_  Hepatitis B  Polio  Influenza  
(immunization date)

List all medications you are presently taking:

Dosage (mg):

Frequency (once, twice, etc., per day)

List all medications you are presently taking:	Dosage (mg):	Frequency (once, twice, etc., per day)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you taken cortisone-type drugs?  Yes  No  
Have you ever had your blood products transfused?  Yes  No  
If yes, when? \_\_\_\_\_

When was your most recent proctoscopic/sigmoidoscopic/barium enema/colonoscopic exam? \_\_\_\_\_

What is your height? \_\_\_\_\_

What is your usual weight? \_\_\_\_\_

How long have you been at this weight? \_\_\_\_\_

**FEMALES ONLY:**

Date of last PAP: \_\_\_\_\_  Normal  Abnormal  
Last menstrual period: \_\_\_\_\_  
Date of last mammogram: \_\_\_\_\_  
Periods are:  Regular  Irregular  Pain  Cramps  
Number of pregnancies: \_\_\_\_\_  
Number of miscarriages: \_\_\_\_\_  
Birth control method: \_\_\_\_\_

Is there any other information you would like your Executive Health physician to know?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you would like a summary of your medical findings sent to your primary care physician, please complete the following:

Physician name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

**You may fax the completed form to 703.717.4701.**