



SURGICAL ASSOCIATES

AT VIRGINIA HOSPITAL CENTER

Please provide the following information. This information will help your physician provide excellent care not only based on your health and medical history but also on the relevant information about your immediate family and other relatives.

NEW PATIENT MEDICAL HISTORY

Patient's Full Name _____

Today's Date: _____ Date of Birth: _____

Social Security Number: _____ - _____ - _____ Gender: F _____ M _____

Address: _____

Home number: (____) ____ - _____ Work number: (____) ____ - ____ Mobile number: (____) ____ - ____

Full name of Insured (if other than patient): _____

Are you currently employed? Yes _____ No _____ Retired _____ Martial Status: _____

If yes, what is your current occupation? _____ Company name: _____

Reason for visit: _____

Referring Physician: _____

Office Phone: _____ Fax: _____

Primary Care Physician: _____

Office Phone: _____ Fax: _____

Medications

Please list all current medications. Please include dosage (mg) and frequency (once, twice per day, etc)

Medication:	Dosage (mg):	Frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all allergies and reactions to any medications.

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

Medication:	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have a Latex allergy? Yes ___ No ___

Social History

Number of children: _____ Ages: _____

Tobacco use: Never ___ Now ___ Past ___ How much per day? _____ # of years? _____
When did you quit? _____

Recreational Drug Use? Never ___ Now ___ Past ___ How much per day? _____ # of years? _____
Drug(s) used? _____ When did you quit? _____

Alcohol Consumption? Never ___ Now ___ Past ___ How much each day? _____
For how many years? _____ When did you quit? _____

Caffeine Use: Never ___ Now ___ Past ___ Cups per day: Coffee ___ Tea ___ Soda ___

Personal Medical History

Please check all illnesses or conditions which you have now or in the past:

- Asthma
- Diabetes
- Glaucoma
- Hepatitis A, B or C
- High Blood Pressure
- Nervous Disorder
- Pneumonia
- Tuberculosis
- Thyroid problems, Type _____
- Elevated Cholesterol
- Blood Clots
- Depression
- Bleeding Tendencies
- Cancer, Type _____
- HIV
- Jaundice
- Arthritis/Gout
- Sleep Apnea
- Heart Murmur
- Heart Trouble, Type _____

- Kidney Disease
- Stroke/TIA
- Obesity

- Reflux, Peptic Ulcer
- Difficultly Breathing/ Shortness of Breath

Please list all surgeries

Please list all hospitalization

Surgery:	Year:	Hospitalization:	Year:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever had any serious injuries, broken bones, etc? Yes___ No___
 If yes, please list: _____

Family History

Please check illnesses that have occurred in any of your blood relatives and indicate which relative:

- Stroke Relative(s): _____
- High Blood Pressure Relative(s): _____
- Heart Disease Relative(s): _____
- Bleeding Tendencies Relative(s): _____
- Urinary Tract Infection Relative(s): _____
- Cancer Relative(s): _____
- Kidney Disease Relative(s): _____
- Kidney Stones Relative(s): _____
- Diabetes Relative(s): _____
- Mental Illness Relative(s): _____
- Alcoholism Relative(s): _____

Living:	Age or Age at death:	Significant health problems or cause of death and age at death:
Mother: Yes___ No___	_____	_____
Father: Yes___ No___	_____	_____
Spouse/Partner: Yes___ No___	_____	_____
Brothers: Yes___ No___	_____	_____
Sisters: Yes___ No___	_____	_____
Children: Yes___ No___	_____	_____

Review of Symptoms

Do you now have or ever had the following:

Significant weight change	Yes__	No__
Increase/Decrease by how many pounds	+lbs__	-lbs__
Any eye disease, injury, impaired sight	Yes__	No__
Convulsions	Yes__	No__
Pain radiating down arm	Yes__	No__
Any trouble with nose, sinuses, mouth, and throat	Yes__	No__
Shortness of breath	Yes__	No__
Bleeding gums	Yes__	No__
Burning pain during urination	Yes__	No__
Trouble swallowing	Yes__	No__
Loss of bladder control	Yes__	No__
Chest pain or tightness in the chest	Yes__	No__
Blood in urine	Yes__	No__
Coughing up blood	Yes__	No__
Frequent Urination	Yes__	No__
Night Sweats	Yes__	No__
Trouble with erections	Yes__	No__
Palpitations	Yes__	No__
Painful intercourse	Yes__	No__
Swelling of hands or feet	Yes__	No__
Breast lumps	Yes__	No__
Weakness in arm or leg	Yes__	No__
Frequent or severe headaches	Yes__	No__
Varicose veins	Yes__	No__
Paralysis	Yes__	No__
Stomach trouble or ulcer	Yes__	No__
Enlarged glands	Yes__	No__
Constipation or diarrhea	Yes__	No__
Enlarged thyroid or goiter	Yes__	No__
Hemorrhoids or rectal bleeding	Yes__	No__
Pain in joints or gout	Yes__	No__
Fainting spells	Yes__	No__
Skin irritation or rashes	Yes__	No__
Loss of consciousness	Yes__	No__
Depression or anxiety	Yes__	No__
Spells of dizziness	Yes__	No__
Hallucinations	Yes__	No__

Females only

Date of last PAP: _____	Normal__	Abnormal__
Last menstrual period: _____	Normal__	Abnormal__
Date of last Mammogram: _____	Normal__	Abnormal__
Number of pregnancies: _____		
Number of miscarriages: _____		
Birth control method: _____		
Periods are: Regular _____	Irregular _____	Painful _____ Cramps _____