Virginia Medical Alliance

vma

PATIENT MEDICAL HISTORY

Name:_____ D.O.B.: _____ Age: _____ Sex: _____
Married: _____ Single: _____ Divorced: _____ Separated: _____ Widow: _____
Ethnic Origin: _____ Occupation: _____

Social History

Smoke: ( ) Yes ( ) No **If Yes**: Packs Per Day: _____ Years Smoked: _____
Alcohol Use: _____ Exercise: (Hrs/Wk) _____ Sleep: (Hrs/Day) _____

Females

Last Menstrual Period: _____ Menopausal Symptoms: _____
# of Pregnancies: _____ # of Children: _____
Last Pap Smear: _____ Last Mammogram: _____
Have you ever had a Hysterectomy: _____ If yes, were your Ovaries removed: _____

Medications: _____
Drug Allergies: _____
Past medical Problems: _____
Past Operations: _____
Serious Injuries: _____
Diagnostic Studies: (X-rays, exercise, stress test, sigmodoscope, etc.) _____

Family Medical History: (Hypertension, Diabetes, Stroke, Heart disease, Lung disease, Liver disease, Kidney disease, TB, Cancer (what kind?)

Mother: _____ Father: _____
Grandmother: _____ Grandfather: _____
Siblings: _____ Children: _____
Aunts: _____ Uncles: _____

Immunizations:

Last Tetanus: _____ Last PPD: _____

5510 Alma Lane, Springfield, VA 22151