

Manassas Internal Medicine Patient Questionnaire

Name: _____ DOB: __/__/____ Gender: _____ Date: _____

Reason for Visit: _____

Past Medical History:

- | | | | | |
|---|--|--|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disorder | <input type="checkbox"/> Skin Disorder |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Lung Disorder | <input type="checkbox"/> Thyroid Disorder |

Medications

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies:

Name of Medication	Reaction
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Surgical History

_____	_____
_____	_____
_____	_____

Colonoscopy:

Women:

Last Pap _____ Last Mammogram _____

Family History

Do you have a family history of any of the following conditions? (Check all that apply)

- | | | | | |
|---|--|---|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Genetic Disorder | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anxiety disorder | <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver disorder | <input type="checkbox"/> Thyroid Disorder |

If you checked any of the above conditions, please identify who in your family has the condition(s).

Social History

Tobacco use: Current Former Never Packs per day: _____ Alcohol use: Yes No # of drinks/week _____

Currently sexually active? Yes No # of partners in the past year _____ Would you like STD screening today? Yes No

Recreational drug use: Yes No Which drug(s)? _____ # of times/week _____

Caffeine intake: # of drinks/day _____ How often do you exercise? # of times/week _____