## **Manassas Internal Medicine Patient Questionnaire**

Name:				DOB:	//	_Gender:	Date:	
Reason for Visit:								
Past Medical Histor	•							
Alcoholism	☐ Back Probler		□Epilepsy		☐ High Choles		Osteoporosis	
☐ Anxiety/Depression	□Blood Disord		Glaucoma		☐ Kidney Dison☐ Liver Dison		Stroke	
□ Arthritis □ AIDS/HIV	□Cancer □Diabetes		☐ Heart Disease ☐ Hypertension		☐ Liver Disor		∃Skin Disorder ∃Thyroid Disorder	
•	Diabetes				o .	uei i	1 Hyroid Disorder	
Medications				<u>Allergi</u>	es:			
Name Dose		Frequency		Name of Medication		Read	Reaction	
				Surgical History				
Name	Dose	Frequenc		<u>ourgrea</u>				
Name	Dose	Frequenc	<b>y</b>					
Name	Dose	Frequenc	<b>y</b>					
Name	Dose	Frequenc	<u>y</u>					
Name	Dose	Frequenc		Colono	scopy:			
Name	Dose	rrequenc	y					
Name	Dose	Frequenc	<b>y</b>	<u>Wome</u>	n: Last Pap	Last N	/lammogram	
Family History								
Do you have a family his	tory of any of the	following c	onditions? (Che	eck all tha	it apply)			
$\square$ Alcoholism	☐ Back Problems		□ Diabetes	□ Diabetes		Blood Pressure	☐ Lung Disease	
□Anemia	☐ Cancer	□Cancer		☐ Genetic Disorder		holesterol	Osteoporosis	
☐ Anxiety disorder	☐ Blood disorders		□Glaucoma		☐ Kidney Disorder		□Stroke	
□Arthritis	☐ Depression		☐ Heart Dise	☐ Heart Disease		disorder	☐Thyroid Disorder	
If you checked any of the	above condition	ıs, please ide	entify who in yo	our family	has the cond	ition(s).	·	
Social History								
Tobacco use: □Current	□Former □Neve	er Packs pe	r day: A	lcohol us	e: □Yes □No	# of drinks/w	reek	
Currently sexually active		_						
Recreational drug use: [		_					-	
Caffoing intake: # of drin								