HealthWorks FOR NORTHERN VIRGINIA

Patient Name: _____ **Date of Birth:** _____

Date of Visit: _____ **Reason for Visit:** _____

MEDICAL HISTORY

Do you have any of the following:

	YES	NO		YES	NO
Asthma			Seizures		
Heart Disease			Hepatitis		
High Blood Pressure			Depression		
Diabetes			Anxiety		
Difficulty breathing			High Stress Level		
Kidney Disease			Alcoholism		
Liver Disease			Cancer:		
Bleeding Disorder			Other:		
Thyroid Disease					

Do you have any allergies: □ None □ Yes

If yes, please specify

_____

Current medications: □ None □ Yes

If yes, please specify

_____

_____

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SOCIAL HISTORY

Do you use any of the following: □ Alcohol □ Tobacco □ N/A

Have you been in any accidents recently: □ Yes □ No

If yes, please specify_____

Have you fallen recently: □ Yes □ No

If yes, please specify_____

Have you had any past surgeries: □ Yes □ No

If yes, please specify_____

Is there any procedure or surgery scheduled for you: □ Yes □ No

If yes, please specify _____

Have you had a colonoscopy in the past 12 months: □ Yes □ No

If yes, please specify_____

Any other info you would like us to know about your health history:

_____

_____

FOR WOMEN ONLY

Have you received a pap smear in the last year: □ Yes □ No

If yes, please specify _____

Have you had a pelvic exam in the last year: □ Yes □ No

If yes, please specify _____