Virtua Health

Medical Group **Health History** Date: ________________

Name: ______________________ Date of Birth: ______________ Age: ________
Referring Doctor: ______________________ How did you hear about us? ____
Reason for Today's Visit: ______________________ Goals for Health: ______________________
Employer: ______________________ Job Title: ______________________
Marital Status? M S D W Previous PCP ______________________

Allergies to Medications, X-Ray Dyes, Latex, Tape or Other Substances	Reaction

Current Medications (Prescription, Over the Counter, Vitamins, Herbs, etc.) Please bring medication bottles with you to your appointment.

Drug Name, Dose, Reason For Taking, Prescribing Clinician	Frequency	Drug Name, Dose, Reason For Taking, Prescribing Clinician	Frequency
1)		4)	
2)		5)	
3)		6)	
4)		8)	

Surgeries and Hospitalizations

Surgery/Procedure Type	Date	Hospitalization Reason	Date
1)		1)	
2)		2)	
3)		3)	

Vaccinations: Please provide a record of all vaccinations if possible.

	Date		Date
DTAP		HPV	
FLU		MENINGOCOCCAL	
HEP A		PREVNAR 13	
HEPB		TDAP/TD	
SHINGLES		PNEUMOCOCCAL 23	

Specialists:

Name	Specialty	Conditions Treated
1.		
2.		
3.		
4.		
5.		

Would you like to have the flu shot today (September through March) Yes No
Would you like to have the pneumonia vaccine (age 65 years and older) Yes No

Social History Please indicate if you have in the (**P**ast), current (**C**urrent), or never (**N**ever) any of the following:

	P C I		
Do you smoke?		If past or current, how many packs per day?	How many years?
Do you use street drugs?		If past or current, what type?	
Do you drink alcoholic beverages?		If past or current, how much per week?	
Caffeine usage?		If past or current, how many cups per day?	
Have you ever worked with chemicals, paints, asbestos or other hazardous materials?		If yes, please explain:	
Do you follow any specific diet?	**Yes No**	If yes, please explain:	
Do you exercise on a regular basis?	**Yes No**	If yes, how many times per week:	

Prevention

	Yes	No
Do you wear seat belts?		If no, why not?
Do you wear a bike helmet?		
Is there a gun in your home If so, is it unloaded and locked in a gun safe?		
Have you ever engaged in any activity which has put you at risk of getting a sexually transmitted disease?		If yes, explain:
Do you wish to be tested for a sexually transmitted disease?		
Do you feel safe at home?		
Do you have smoke/carbon monoxide detectors in your home?		

Virtua Health

Health History

Patient Name: **Date of Birth:**

Medical History

Please indicate if you have ever had problems with any of the following: P= Past C= Current N= Never

P	C	N		P	C	N		P	C	N		P	C	N	
			AIDS/HIV				Deep Vein Thrombosis				High Blood Pressure				Sexual Transmitted Disease
			Amputations				Diabetes, Type ________				High Cholesterol				Skin Disease
			Anemia				Eating Disorder				Irritable Bowel Syndrome				Stroke
			Anxiety				Epilepsy				Kidney Disease				Suicide Attempt
			Appendicitis				GERD/Ulcer Disease				Kidney Stones				TB/Positive PPD
			Arthritis				Glaucoma				Liver Disease				Thyroid Problems
			Asthma				Gout				Migraine Headaches				Vascular Disease
			Bipolar Disorder				Hay Fever				Multiple Sclerosis				Other:
			Bleeding Disorders				Heart Disease				Neuropathy				1.
			Blood Disorders				Heart Murmur				Pacemaker				2.
			Cancer				Hemorrhoids				Rheumatic Fever				3.
			COPD/Emphysema				Hepatitis				Seizures				4.

Family History:

Has any member of your family (including parents, grandparents and siblings) ever had the following?

Illness	Family Member (maternal grandmother, brother, etc)	Approximate Age When Diagnosed	Living or Deceased and Deceased Reason
Cancer (describe type)			
Diabetes			
Drug or Alcohol Addiction			
Heart Disease			
Hyperlipidemia (High Cholesterol)			
Hypertension (High Blood Pressure)			
Mental Disease (Anxiety, Depression, etc.)			
Stroke			
Other:			
Other:			
Other:			
Other:			

Women's Health:

Age of First Period: _________ Are You Sexually Active: Yes No Sexual Preference:_______________Method of Birth Control:___________________

Have you ever taken Hormone Therapy? YES NO If yes, what kind? ______________________________________

If no, are you interested? _______________________________

Have you, or are you currently, going through menopause? YES NO If yes, what year? ____

Are you currently pregnant? YES NO Are you contemplating pregnancy? YES NO

Are you breastfeeding? YES NO Do you have difficulty conceiving? YES NO

History: Please indicate if you have ever had problems with any of the following: P= Past C= Current N= Never

P	C	N		P	C	N		Procedure:	Date of Procedure:
			Abnormal Bleeding				Nipple Discharge	Colposcopy	
			Breast Lump				Painful Intercourse	Leep	
			Extreme Menstrual Cramps				Pre-eclampsia	D&C	
			Gestational Diabetes				Vaginal Infections		
			Hot Flashes				Cervical Cryotherapy		

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Pregnancies:

Year	Outcome: (Miscarriage/Abortion/Live Birth)	Vaginal/C-Section	Living Child

Preventive Testing:

	Date of Last Test	Performed where/by who?	Results?	Ever abnormal in past?	What was the management or follow up?
Pap					
Mammo					
DEXA					
Colonoscopy					

I CERTIFY THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOT HOLD MY DOCTOR OR ANY MEMBERS OF HIS/HER STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

Patient Signature

Date

Revised 10-16-19