DULLES FAMILY MEDICINE
504 ELDEN STREET
HERNDON, VA. 22070
(703) 471-0800

# PATIENT HISTORY QUESTIONARE

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

**Date of Last Physical Exam:** _____ **Allergies:** _____

**Reason For Visit:** _____

**Symptoms:** _____

**Routine Checkup – No Symptoms:** _____

| **FAMILY HISTORY** Specify any relatives with the following conditions | **LIVING** | **DECEASED** |
|---|---|---|
| | **RELATIONSHIP** | **RELATIONSHIP** |
| Cancer | | |
| Diabetes | | |
| Heart Trouble | | |
| High Blood Pressure | | |
| Stroke | | |
| Epilepsy | | |
| Kidney Disease | | |
| Emotional Problems | | |
| Asthma | | |
| Breast Disease | | |
| Migraine Headaches | | |

**Habits:**
**Do you smoke?** _____
**How much?** _____
**Do you drink alcohol?** _____
**How much & how often?** _____
_____
**Do you use drugs? (marijuana, cocaine, crack, etc)** _____
**Do you drink coffee?** _____
**How much?** _____
**Present Medications:** _____
_____
**Do you have a living well/advance directiv**
_____

**Please Circle Any of the Following You Have Had:**

Headaches
Heart Disease
High Cholesterol
Kidney Disease
Liver Disease
Hepatitis
Ulcers
High Blood Pressure
Stroke
Cancer
Head Injury
Broken Bones
Asthma
Bowel Problems
Gallbladder Disease
Anemia
Diabetes
Thyroid Disease
Seizures
Depression
Substance Abuse
Blood Transfusion
Breast Disease
Back Problems
Skin Problems
Lung Disease

**Women Only:**
Menstrual History
Age at Onset: _____
Regular: Yes No
Flow:
Heavy Medium Light
Severe Cramping? Yes No
Date of Last Period: _____
Date of Last Pelvic Exam: _____
Date of Last Pap Smear: _____
Method of Contraception
Number of Pregnancies: _____
Number of Live Births: _____
Do You Perform Monthly Breast Exams? _____

**Men Only:**
Do you get up at night to urinate? _____
Do you have difficulty starting urinary stream? _____
Do you perform monthly testicular exams? _____
Do you have discharge from penis? _____