Right Primary CareLLC / NOVA House Call MD
6521 Arlington Blvd Suite #410
Falls Church, VA 22042

MEDICAL QUESTIONNAIRE

PATIENT NAME____

DOB____________________ **DATE**_____________________

MEDICAL PROBLEMS BEING TREATED/ OR EVER TREATED BY A DOCTOR

Date/Duration **Problem** **Treatment**

SURGERIES (INCLUDING EYE SURGERY AND DERMATOLOGIC PROCEDURES)

Date **Surgery/Treatment**

HOSPITALIZATIONS (DATES/ REASON FOR ADMISSION)

Date **Reason for Admission**

MEDICATIONS (INCLUDING NONPRESCRIPTION MEDS)
WITH PRESCRIPTION STRENGTH AND DOSE

Medication **Strength** **Dose**

Revised on June. 10, 2010

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ALLERGIES/ SENSITIVITIES

SOCIAL HISTORY
SMOKE CIGARETTES
ALCOHOL USE
PARTNER/ SIGNIFICANT OTHER
CAREER/JOB

FAMILY HISTORY (DISEASES IN FIRST OR SECOND DEGREE RELATIVES)
MOTHER
FATHER
SIBLINGS
CHILDREN
OTHER DISEASES IN FAMILY MEMBERS

PREVENTATIVE
EXERCISE (times /week)/ strenuous vs. non-strenuous

DIET –typical

(date of last test)

MAMMOGRAM-
COLONOSCOPY-
STOOL SCREENING-
PAP (date/ result)-
Cholesterol (date/ cholesterol)- /
BP (date- BP)- -
Bone Density (date/ T-score (hip/ spine)) / (/)

IMMUNIZATIONS/ VACCINATIONS (date received)
TETANUS
HEP B
INFLUENZA
PNEUMOVAX
MEASLES
MUMPS
RUBELLA
Tb/ PPD/ BCG

Signature of Person Completing Form/ Relationship: ___________________________

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