EXECUTIVE HEALTH at
VIRGINIA HOSPITAL CENTER

1625 N. George Mason Drive | Suite 435 | Arlington, VA 22205
703.717.4700 *tel* | 703.717.4701 *fax*

Patron Information

Please answer the following questions. It will help your physician to provide excellent care not only based on your health and medical history but also based on relevant information about your immediate family and other relatives. By completing this form you also acknowledge that you have been provided with a copy of Virginia Hospital Center's Privacy Notice and that you understand that the information you provide will only be used for treatment, payment and Hospital operations as described in the Notice and in accordance with applicable federal and state laws and regulations.

Referred by (if applicable): _____

Your Full Name: _____ Gender: F ☐ M ☐

Address: _____City:_____ State: _____ Zip: _____

Today's Date: _____Date of Birth: _____ Social Security Number: _____

Daytime Phone: _____ Evening Phone: _____

Full Name of Spouse: _____

Are you employed? ☐ Yes ☐ No ☐ Retired

If yes, what is your occupation? _____ Company Name: _____

Have you traveled outside of the USA and/or Canada in the past five years? ☐ Yes ☐ No
If yes, where?_____

Family History

	Living	Present age or age at death	Significant health problems or cause of death
Father	☐ Yes ☐ No	_____	_____
Mother	☐ Yes ☐ No	_____	_____
Spouse/Partner	☐ Yes ☐ No	_____	_____

			Significant health problems or cause of death
Brothers	Number living	_____	_____
	Number dead	_____	_____
Sisters	Number living	_____	_____
	Number dead	_____	_____
Children	Number living	_____	_____
	Number dead	_____	_____

Present marriage (years): _____ Previous Marriage (s) (years): _____

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Personal Medical History:

Please check illnesses that have occurred in any of your **blood** relatives:

□ Stroke □ Cancer □ Diabetes □ High Blood Pressure
□ Heart Disease □ Kidney Disease □ Nervous Disease □ Bleeding Tendencies

Please check illnesses or conditions which you have had:

□ Asthma □ Bleeding Tendencies □ Cancer □ Diabetes
□ Glaucoma □ HIV □ Heart Trouble □ Hepatitis
□ High Blood Pressure □ Jaundice □ Kidney Disease □ Nervous Disorder
□ Pneumonia □ Rheumatic Fever □ Stroke/TA □ Tuberculosis
□ Hypothyroidism □ Sleep Apnea □ Obesity □ Elevated Cholesterol
□ Blood Clots □ Heart Murmur □ Reflux/Peptic Ulcer Disease
□ Other:_____

What type of exercise or physical activities do you perform and how frequently?

_____
_____
_____
_____

Previous surgeries (please list procedure and year):

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Have you had any serious injuries, broken bones, etc.? □ Yes □ No
If yes, please list: _____

Have you ever had an allergic reaction to any medications? □ Yes □ No
If yes, list medications and describe reactions:

_____

Have you ever had an allergic reaction to X-ray contrast dye? □ Yes □ No
If yes, please describe: _____

Have you ever had a latex allergy? □ Yes □ No
If yes, please describe: _____

Have you ever had a tape allergy? □ Yes □ No
If yes, please describe: _____

Tobacco use: □ Never □ Now □ In the Past
How much each day?_____ For how many years? _____
When did you quit? _____

Alcohol use: □ Never □ Now □ In the Past
How much each day?_____ For how many years? _____
When did you quit? _____

Recreational Drug Use: □ Never □ Now □ In the Past
How much each day?_____ For how many years? _____
When did you quit? _____

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Please check the immunizations you have received:

☐ Tetanus/TB (recommended every 10 yrs) _____ (immunization date) ☐ Hepatitis A ☐ Measles ☐ German Measles (Rubella)

☐ Pneumoccal Pneumonia (recommended every 6 yrs) _____ (immunization date) ☐ Hepatitis B ☐ Polio ☐ Influenza

List all medications you are presently taking:	Dosage (mg):	Frequency (once, twice, etc., per day)

Have you taken cortisone-type drugs? ☐ Yes ☐ No
Have you ever had your blood products transfused? ☐ Yes ☐ No
If yes, when? _____
When was your most recent proctoscopic/sigmoidoscopic/barium enema/colonoscopic exam? _____

What is your height? _____
What is your usual weight? _____
How long have you been at this weight? _____

FEMALES ONLY:

Date of last PAP: _____ ☐ Normal ☐ Abnormal
Last menstrual period: _____
Date of last mammogram: _____
Periods are: ☐ Regular ☐ Irregular ☐ Pain ☐ Cramps
Number of pregnancies: _____
Number of miscarriages: _____
Birth control method: _____

Is there any other information you would like your Executive Health physician to know?

_____
_____
_____
_____
_____
_____
_____
_____

If you would like a summary of your medical findings sent to your primary care physician, please complete the following:
Physician name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

You may fax the completed form to 703.717.4701.