TYSONS INTERNAL MEDICINE AND WELLNESS CENTER

PATIENT INFORMATION

First Name: _____ Last Name: _____ Sex: M ( ) F ( )

Address:_____ City:_____ State:_____ Zip:_____

Home phone: _____ Cell: _____ Email _____

DOB: Month____ Day____ Year _____ Race: _____ Marital Status: _____

Employer _____ Address _____

Phone _____ Occupation _____ Education _____

EMERGENCY CONTACT:

First Name:_____ Last Name: _____ Relationship to patient: _____

Home phone: _____ Cell phone: _____

INSURANCE INFORMATION:

Insurance Name: _____ Policy Holder: _____

Member ID: _____ Group number: _____

PREFERRED PHARMACY:

Name: _____ Phone: _____

Address: _____

1. Tysons Internal Medicine and Wellness Center does not guarantee insurance coverage as payment.
2. If your insurance company does not settle your claim within 90 days of claim submission, then you will be billed for the services.
3. All non-covered services need to be paid at time of visit.
4. All co-payments need to be paid at the time of the visit.
5. There will be **a $50 charge** for any missed appointment without **24 hour cancellation notice.**

Signature _____ Date _____

PAST MEDICAL HISTORY (Please check all that apply)

( )Abnormal Mammogram	( ) Cancer	( ) Heart Disease	( ) Mental Illness _____
( ) Abnormal Menstruation	( ) Chronic Headache	( ) Hernia	( ) Prostate Disease
( ) Abnormal Pap Smear	( ) Circulation Problem	( ) High Blood Pressure	( ) Rheumatoid Arthritis
( ) Abnormal T.B. test	( ) Colon Polyp	( ) High Cholesterol	( ) Seizure or Epilepsy
( ) Acid reflux	( ) Depression	( ) Hemorrhoids	( ) Sexually Transmitted Disease
( ) Active Tuberculosis (T.B.	( ) Diabetes	( ) HIV or AIDS	( ) Skin disease _____
( ) Allergies/Hay Fever	( ) Diverticulosis	( ) Intravenous Drug Use	( ) Stomach Ulcer
( ) Anemia	( ) Dialysis	( ) Liver Disease/Hepatiti	( ) Stroke
( ) Asthma	( ) Eating Disorder	( ) Lung Disease	( ) Thyroid Disease
( ) Blood Product Transfusion	( ) Gall Bladder Disease	( ) Lupus	( ) Other_____

FAMILY HISTORY: (Please check all that apply and indicate relationship to family member)

( ) Asthma	( ) Depression	( ) High Cholesterol	( ) Prostate Cancer	( ) Tuberculosis
( ) Bleeding Disorder	( ) Diabetes	( ) Mental Illness	( ) Skin Cancer	( ) Thyroid Disease
( ) Breast Cancer	( ) Heart Attack	( ) Osteoporosis	( ) Stroke	( ) Ovarian Cancer
( ) Colon/Rectal Cancer		( ) High Blood Pressure		( ) Other _____

MEDICATIONS: List current medications and doses (incl. birth control or shots, non- prescription drugs, vitamins, supplements, ointments, creams, nasal sprays, inhalers and eye drops_____

_____

_____

HOSPITALIZATIONS /MAJOR EVENTS _____

_____

_____

ALLERGIES to any medications (please list): _____

Allergic to: ( ) Latex ( ) Iodine/Dye ( ) Metal ( ) Food Allergies _____

PREVENTIVE CARE: Check and date all that apply: ( ) Mammogram _____ ( ) Pap Smear _____

( ) DEXA Scan _____ ( ) Colonoscopy _____ ( ) Physical _____

( ) Last Dental Exam _____ ( ) Last Eye Exam _____

IMMUNIZATIONS: (Check if you had the disease or received the vaccine and list the year)

( ) Diptheria/Tetanus _____	( ) Pneumonia _____
( ) Hepatitis A _____	( ) Polio _____
( ) Hepatitis B _____	( ) Small Pox _____
( ) Gardisil (HPV Vaccine) _____	( ) T.B.Skin Test _____
( ) Influenza _____	Result: Positive/negative
( ) Measles/Mumps German Measles _____	Treatment: _____
( ) Meningitis _____	( ) Zostavax _____

Concerns/ Comments:

Patient Signature: _____ **Date:** _____

☐ **I acknowledge that this history is correct and complete.**

SOCIAL HISTORY

Marital Status: _____ Children: _____ Occupation _____

Smoking Status ( ) Never smoked ( ) Now smoking ( ) Used to smoke ( ) Chew Tobacco

If smoking _____ cigarettes/packs per day/week

Alcohol type _____ Amount _____ per day/week

Street drugs including marijuana, cocaine, heroin and other mood altering drugs or pills _____

Caffeinated beverages (coffee, tea, soda, etc.) _____ per day/week Guns in the home? ( ) Y ( ) N

Do you consistently wear seatbelts? ( ) Y ( ) N

Sexual orientation ( ) Heterosexual ( ) Homosexual ( ) Bisexual ( ) Other

Do you eat well? _____ How do you feel about your weight? _____

Exercise type _____ How often? _____

Are you an organ donor? ( ) Y ( ) N Do you have a living will? ( ) Y ( ) N

FEMALES ONLY

Menstruation: Age of onset _____ Flow: ( ) regular ( ) irregular ( )heavy ( ) moderate ( ) light

Number of pregnancies _____ Last Pap Smear ( ) normal ( ) abnormal

Number of live births _____ Last Mammogram ( ) normal ( ) abnormal

Number of abortions _____ Number of ectopic pregnancies _____

Number of miscarriages _____ Age at first pregnancy _____

Are you currently pregnant? ( ) Y ( ) N Are you breastfeeding? ( ) Y ( ) N

Any post-menopausal vaginal bleeding? ( ) Y ( ) N

MALES ONLY

Do you practice testicular self- exam? ( ) Y ( ) N Do you have urinary frequency? ( ) Y ( ) N

Is there a history of impotence? ( ) Y ( ) N Do you awaken at night to urinate? ( ) Y ( ) N

Do you have a urethral (penile) discharge? ( ) Y ( ) N Do you regularly use condoms? ( ) Y ( ) N

HEIGHT _____ WEIGHT _____