# OLD DOMINION MEDICAL CENTER

6715 Whittier Avenue, Mclean, Va 22101

## HEALTH HISTORY

Chart # _____

PATIENT INFORMATION

| First Name: | M.I. | Last Name: | Date Of Birth: (MM/DD/YY) |
|---|---|---|---|
| | | | |

To help meet all your healthcare needs, please fill out this form completely.
This is a confidential record of your medical history and will be kept with your medical record.

1

Have you ever been diagnosed with any of the following? (Please check all that apply to you):

| Diagnosis | Type (If Known) |
|---|---|
| ☐ Diabetes | |
| ☐ Hypertension | |
| ☐ Depression | |
| ☐ Insomnia | |
| ☐ Anxiety | |
| ☐ Stroke | |
| ☐ Eczema | |
| ☐ Migraines | |
| ☐ Elevated Cholesterol | |
| ☐ Cancer | |
| ☐ Heart disease | |
| ☐ Blood Disease | |
| ☐ Thyroid Disease | |
| ☐ Kidney Disease | |
| ☐ Substance Abuse | |
| ☐ Allergies | |
| ☐ Other | |

2

Do you frequently experience any of the following? (please check all that apply to you):

**General**
- ☐ Unexplained weight loss
- ☐ Fatigue
- ☐ Lightheadedness
- ☐ Sleeping problem

**Endocrine**
- ☐ Heat or cold intolerance
- ☐ Irregular menstrual period

**Pulmonary**
- ☐ Shortness of breath
- ☐ Persistent cough
- ☐ Wheezing

**Musculoskeletal**
- ☐ Joint pains
- ☐ Muscle pains

**Neurology**
- ☐ Numbness
- ☐ Tingling in extremities
- ☐ Visual changes
- ☐ Headaches

**Hematology**
- ☐ Easy bruising
- ☐ Prolonged bleeding

**Urinary**
- ☐ Urinary incontinence
- ☐ Frequent urination
- ☐ Erectile dysfunction

**Gastrointestinal**
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Blood in stool

**Cardiac**
- ☐ Chest pains
- ☐ Palpitations

**Psychiatric**
- ☐ Depressed mood
- ☐ Anxious thoughts
- ☐ Difficulty concentrating

3

Social History

Marital Status: Single / Married / Divorced / Separated / Widowed

Occupation: _____

Exercise: YES / NO Frequency: _____ Type _____

Tobacco: YES / NO How much/often _____

Alcohol: YES / NO How much/often _____

4

Have any family member(s) ever been diagnosed with any of the following? (If yes, please indicate which family member):

Cancer: YES / NO Type: _____ Family Member(s) _____

Hypertension: YES / NO Type: _____ Family Member(s) _____

Heart Disease: YES / NO Type: _____ Family Member(s) _____

Diabetes: YES / NO Type: _____ Family Member(s) _____

Stroke: YES / NO Type: _____ Family Member(s) _____

Mental Disease: YES / NO Type: _____ Family Member(s) _____

Other: YES / NO Type: _____ Family Member(s) _____

Please list any other information that you believe would be pertinent to the doctor: _____

_____

_____

_____ _____

Patient or Guardian Date

Allen B. Horne, MD Fredrick W. Hubach, MD Ritu B. Cuttica, DO Patricia Leighton, NP