

WASHINGTON MEDICAL GROUP, P.C.

Initial Visit Questionnaire

***Please print clearly.**

Name: _____

Date: _____ Age: _____

Specific reason for visit (max 2): _____

Date of last Physical Examination: _____

Date of last Menstrual Cycle if applicable: _____

When did symptoms begin (Date of Onset): _____

Current medications, dosage and direction: _____

Allergies: _____

Tobacco usage: y/n _____ How much: _____

Alcohol usage: y/n _____ How much: _____

Employment: _____

Highest level of education: _____

Medical History

***Please check all that applies either to you or your family and please give specific details. Print clearly.**

Illness/medical history	Self	Family	Details
Accident			
ADHD			
Arthritis			
Asthma			
Blood Disorder			
Cancer			
Dementia			
Depression			
Diabetes			
Eye Disorder			
Glasses/contacts			
Head Trauma			
Hearing Disorder			
Heart Disease			
High Cholesterol			
Hypertension			
Kidney Disease			
Learning Disability			
Liver Disease			
Lung Disease			
Mental Illness			
Migraine			
Neurological Disease			
Seizure			
Sinusitis			
Skin Disease			
Spine Disease			
Stomach Disease			
Stroke			
Surgery			
Thyroid Disease			

Any other medical/illness history: _____

Review of Systems

***Please circle any current symptoms you are experiencing for each category.**

Constitutional	Fever, chills, anorexia, excessive sweats, fatigue, general weakness
Eyes	Pain, discharge, irritation from bright lights, vision loss, double vision
Ears, nose, throat	Congestion, sinus pain, ear pain, hoarseness, sore throat
Neck	Neck pain, stiffness, swelling, enlarge lymph nodes
Lungs	Shortness of breath, cough, productive sputum, wheezing, chest pain with breathing, coughing up blood
Heart	Chest pain, difficulty breathing with exertion, difficulty breathing at night, rapid heart beating
Gastrointestinal	Abdominal pain, nausea, vomiting, diarrhea, constipation, black stool, blood in stool, hemorrhoids
Urinary	Pain with urination, frequent urination, urgent urination, blood in urine, loss of control, urination while sleeping
Gynecological	Vaginal bleeding, vaginal discharge, painful intercourse, pregnancy
Skin	Hives, itching, rash, redness
Blood	Easy bruising, prolonged bleeding, swollen lymph glands
Hormonal	Thirsty, weight gain or loss, intolerance to heat
Muscles	Back pain, flank pain, joint pain, muscular pain
Neurological	Headache, dizziness, spinning, numbness, tingling, focal weakness, confusion, memory loss, slurred speech, clumsiness, frequent falls, seizures
Psychological	Stress, anxiety, depression, suicidal, homicidal, hallucinations, paranoid

Signature: _____ Date: _____