CAPITALAREA
INTERNAL MEDICINE

Sree L. Gogineni, MD & Lauren Naughton, MS, PA-C

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2235 Cedar Ln #302
Vienna, VA 22182

44121 Harry Byrd Hwy #250
Ashburn, VA 20147

2010 B Opitz Blvd
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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I): ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	Date of last physical exam:
Race: Ethnicity:	

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐ Other _____

Immunizations and dates:	☐ Tetanus ☐ Hepatitis ☐ Influenza	☐ Pneumonia ☐ Chickenpox ☐ MMR *Measles, Mumps, Rubella*

List any medical problems you have been diagnosed with and when it was resolved, if applicable

SURGERIES

YEAR	REASON	HOSPITAL

OTHER HOSPITALIZATIONS

YEAR	REASON	HOSPITAL

Have you ever had a blood transfusion? **Yes** **No**

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HEALTH HISTORY QUESTIONNAIRE CONT'D

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Mild/Moderate/Severe	Type of Reaction

Non-Drug Allergies

Name the Drug	Mild/Moderate/Severe	Type of Reaction

MENTAL HEALTH		
Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

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HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL

Exercise	☐ Sedentary (No exercise)		
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Diet	Are you dieting?	☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?	☐ Yes	☐ No
	# Of meals you eat in an average day?		
	Rank salt intake: ☐ Hi ☐ Med ☐ Low		
	Rank fat intake ¨ Hi ¨ Med ¨ Low		
Caffeine	☐ None ☐ Coffee ☐ Tea ☐ Cola/Soda		
	# Of cups/cans per day?		
Alcohol	Do you drink alcohol?	☐ Yes	☐ No
	If yes, what do you drink?		
	How many drinks per week?		
	Are you concerned about the amount you drink?	☐ Yes	☐ No
	Have you considered stopping?	☐ Yes	☐ No
	Have you ever experienced blackouts?	☐ Yes	☐ No
	Are you prone to “binge” drinking?	☐ Yes	☐ No
	Do you drive after drinking?	☐ Yes	☐ No
Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No
Other	Do you have a method of Birth Control? If yes, specify:	☐ Yes	☐ No
	Do you take Stimulants/Pep Pills?	☐ Yes	☐ No
	Do you take Tranquilizers?	☐ Yes	☐ No
	Do you take Vitamins? If yes, specify:	☐ Yes	☐ No
	Do you take Laxatives?	☐ Yes	☐ No
	Do you take Sedatives/Sleeping Pills?	☐ Yes	☐ No
Smoking Status	Current Smoker ☐	Former Smoker ☐	Never Smoked ☐
	☐Cigarettes – Per/Day	☐Chew - #/Day	☐Pipe - #/Day ☐Cigars - #/Day ☐Vape X/Day
	☐Start Date:	☐End Date:	

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WOMEN ONLY

Age at onset of menstruation:	
Date of last menstruation:	
Period every _____days	
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes ☐ No
Number of pregnancies _____ Number of live births _____	
Are you pregnant or breastfeeding?	☐ Yes ☐ No
Have you had a D&C, Hysterectomy, or Cesarean?	☐ Yes ☐ No
Any Urinary Tract, Bladder, or Kidney Infections within the last year?	☐ Yes ☐ No
Any blood in your urine?	☐ Yes ☐ No
Any problems with control of urination?	☐ Yes ☐ No
Any hot flashes or sweating at night?	☐ Yes ☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around the time of your period?	☐ Yes ☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes ☐ No
Date of last pap and/or rectal exam?	

MEN ONLY

Do you usually get up to urinate during the night? If yes, # of times? _____	☐ Yes ☐ No
Do you feel pain or burning with urination?	☐ Yes ☐ No
Any blood in your urine?	☐ Yes ☐ No
Do you feel burning or have discharge from your penis?	☐ Yes ☐ No
Has the force of your urination decreased?	☐ Yes ☐ No
Have you had any Kidney, Bladder, or Prostate Infections within the last 12 months?	☐ Yes ☐ No
Do you have any problems emptying your bladder completely?	☐ Yes ☐ No
Any difficulty with erection or ejaculation?	☐ Yes ☐ No
Any testicle pain or swelling?	☐ Yes ☐ No
Date of last prostate and/or rectal exam?	

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PAST MEDICAL HISTORY

Have you ever had the following? If YES, provide age. If NO, leave blank.

Diphtheria	Yellow Jaundice
Chicken Pox	Pancreatitis
Measles	Gallbladder issues
German Measles	Diabetes Specify:
Mumps	High Blood Pressure
Mononucleosis	Stroke
Polio	Kidney Disease
Bronchitis	Bladder issues
Emphysema	Prostate issues
Asthma	Scarlet Fever
Hay Fever	Arthritis Specify:
Rheumatic Fever	Gout
Rheumatic Heart Disease	Bursitis
Angina Pectoris	Epilepsy, Seizures
Heart Attack	Migraine Headaches
Heart Failure	Nervous Breakdown
Heart Murmur	Syphilis
Hiatal Hernia	Gonorrhea
Ulcer	Glaucoma
Diverticulosis	Tuberculosis
Diverticulitis	Histoplasmosis, Sarcoidosis
Hemorrhoids	Herpes Specify:
Parasites (worms)	Anemia
Hernia	Broken Bones Specify:
Liver Disease	Cancer Specify:
Cirrhosis	Other:
Hepatitis	Other:
Thyroid Disease Specify:	Other:

ALLERGIES

Penicillin	☐ Yes ☐	No
Sulfa	☐ Yes ☐	No
Mycins	☐ Yes ☐	No
Morphine	☐ Yes ☐	No
Codeine	☐ Yes ☐	No
Latex	☐ Yes ☐	No
Other		
Other		

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FAMILY HEALTH HISTORY

MARK "X' IF YES, LEAVE BLANK FOR NO

Family Member	If Living, Age	Cancer	Thyroid Disease	Tuberculosis	Diabetes	Ulcer	Heart Disease	Stroke	High Blood Pressure	Kidney Disease	Liver Disease	Alcoholism	Epilepsy	Nervous Breakdown	Asthma	Hay fever	Allergies	Anemia	Blood Disease	Glaucoma	Migraine Headaches	Gout	Arthritis	If Dead, Age at Death	Cause of Death
Father																									
Mother																									
Brother(s)																									
Sister(s)																									
Spouse																									
Child(ren)																									

Cancer Type: _____

Arthritis Type: _____

Thyroid Type: _____