Northern Virginia Internal Medicine & Pediatrics, P.C.

SPECIALIST FOR ADULTS. SPECIALIST FOR KIDS.
CARE FOR THE ENTIRE FAMILY.
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HEALTH HISTORY QUESTIONNAIRE

Patient Name:______________________________ Date of Birth:__________________

	Self	Family		Self	Family		Self	Family
Cancer			Allergy			Gall Stones		
Heart Disease			Joint or Bone Problem			Hepatitis		
Angina			Osteoporosis			Liver Disease		
High Blood Pressure			Arthritis			Thyroid Disease		
High Cholesterol			Gout			Skin Disease		
Stroke			Kidney Disease			AIDS		
Diabetes			Bladder Infection			STD		
Obesity			Bleeding Disorder			Depression		
Lung Disease			Sickle Cell			Suicide		
Tuberculosis			Anemia			Alcoholism/ Drug Addiction		
Emphysema			Blood Clots			Glaucoma		
Chronic Bronchitis			Colitis			Seizure/ Epilepsy		
Asthma			Ulcers			Other ______________		

List medications that you take (prescriptions and non-prescriptions) and the dosage: ______________________

List allergies to medications/ foods, etc.: ____

Have you ever had any surgeries? [ ] Yes [ ] No

If yes, please list name and year: ____

Do you have a Healthcare Living Will/ Durable Power of Attorney? [ ] Yes [ ] No

If yes, have you given a copy to your physician? [ ] Yes [ ] No

Are you an organ donor? [ ] Yes [ ] No

Do you always wear your seatbelt while traveling? [ ] Yes [ ] No

Do you have a smoke detector? [ ] Yes [ ] No

Do you have any health concerns? ____

____

[ ] Check if you would like information about sexually transmitted diseases.

IMMUNIZATIONS

Have you had a Tetanus shot in the last 10 years?	[ ] Yes	[ ] No
Have you had a Pneumoccal vaccine? (65 and over)	[ ] Yes	[ ] No
Do you receive a flu shot annually?	[ ] Yes	[ ] No
Have you had a measles booster?	[ ] Yes	[ ] No

PERSONAL HABITS

Do you use tobacco? [ ] Yes [ ] No — If yes, how much? ____________ How long? ________

Do you drink alcohol? [ ] Yes [ ] No — If yes, how much per week? ______________________

Do you use drugs? [ ] Yes [ ] No — If yes, what kind(s)? ______________________

Do you exercise? [ ] Yes [ ] No — If yes, how many hours per week? ________________

Have you lost/ gained weight in past 6 mos? [ ] Yes [ ] No — If yes, how many pounds? ______________________

Have you had a Cholesterol test in past 5 years? [ ] Yes [ ] No — If yes, was the result elevated? [ ] Yes [ ] No

Do you do breast/ Testicular self exams? [ ] Yes [ ] No — Have you had a dental exam in the past year? [ ] Yes [ ] No

FEMALES ONLY

Have you had any recent abnormal bleeding , discharge or itching? [ ] Yes [ ] No — Number of pregnancies: ______________________

Have you had a thyroid function test? [ ] Yes [ ] No — Number of children: ______________________

Do you take a calcium supplement? [ ] Yes [ ] No — Age periods began: ______________________

Are your periods regular? [ ] Yes [ ] No — Duration of periods (days): ________________

Have you ever had an abnormal pap smear? [ ] Yes [ ] No — Date of last menstrual period: ________________

Have you had any miscarriages? [ ] Yes [ ] No — Date of last mammogram: ________________

Have you had any abortions? [ ] Yes [ ] No — Date of last pap smear: ______________________

Method of birth control: ______________________

Check if you have had any of the following conditions:

Endometriosis	[ ] Yes	[ ] No
Fibrocystic Disease	[ ] Yes	[ ] No
Pelvic Inflammatory Disease	[ ] Yes	[ ] No

________________________________ Patient's Signature

________________________________ Date

Northern Virginia Internal Medicine & Pediatrics, P.C.
Mary Ellen Gallagher, M.D.
2501 N Glebe Road, Ste 301, Arlington, VA 22207

Today's Date: ___/___/___

Patient Name: ______________________________ Gender: __________
First MI Last

Date of Birth: ___/___/___ Marital Status: __________ Social Security #: ______________

Address: ____
Street City State Zip

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________
May we leave a message at this #? ____ May we leave a message at this #? ____ May we leave a message at this # ____

Email: ______________________ Employer: ______________________

Spouse or Parent's Name: ______________________

Person To Contact In Case Of Emergency: ______________________ Phone: ______________

Whom May We Thank For Referring You?: ______________________________

Financially Responsible Party:

Name: ______________________________ Home Phone: ______________
First MI Last

Relationship To Patient: ____________ Is This Person Currently A Patient At Our Office?: ________

Address: ______________________________ Work Phone: ______________
Street City State Zip

Primary Insurance Information:

Insurance Company: ____________ ID #: ____________ Group #: ____________

Address: ______________________________ Phone: ______________
Street City State Zip

Policy Holder's Name: ______________ Date of Birth: ___/___/___ SSN: ______________

Policy Holder's Employer: __________ Relationship To You: __________ Effective Date: __________

Secondary Insurance Information:

Insurance Company: ____________ ID #: ____________ Group #: ____________

Address: ______________________________ Phone: ______________
Street City State Zip

Policy Holder's Name: ______________ Date of Birth: ___/___/___ SSN: ______________

Policy Holder's Employer: __________ Relationship To You: __________ Effective Date: __________

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PRACTICE POLICIES

Payments: All co-payments and previous balances are due at time of service.

Past Due Accounts: If at any time you have a balance due which is more than 90 days old, your account will be referred to an outside collection agency. If your account is submitted to a collection agency, you must pay your balance in full before any services are provided or making an appointment.

Insurance: Your insurance policy is an agreement between you and your insurance company. We are not a party to your contract. We will bill your insurance plan for you, as long as you provide us with accurate information. Please contact your insurance company with any questions regarding coverage. If we are not contracted with your insurance you will need to pay out of pocket/self-pay costs at the time of service. Please be aware that some services you receive may not be covered by your insurance. Charges for services received are your responsibility whether or not your insurance company pays your claim.

Forms & Medical Records: From time to time, various forms and letters, including but not limited to, disability, FMLA and school forms need to be completed. There is a $15 to $50 fee to complete depending on complexity of form/letter. There are fees associated with the copying of medical records. Please inquire at the Front Desk by requesting a Medical Record Release Form.

Returned Check Fee: There is a fee of $40 for any checks returned by your bank.

Prescription Refills: Annual office visits are required for annual prescription refills. Prescription refills not obtained during office visits may be subject to a $25 service charge.

Missed Appointment Fee: If a patient cancels with less than 24 hours notice or fails to show up at all, a missed appointment fee of $25 will be charged. For missed physical appointments a fee of $50 will be charged. This fee must be paid before a new appointment is scheduled.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

I have been given the opportunity to review the Practice's 'Notice of Privacy Practices' which provides a detailed description of how my Protected Health Information (PHI) is used and disclosed.

Patient's Name: ____________________ Signature: ________________________ Date: __________