Tidewater Physicians Multispecialty Group

ADULT PATIENT QUESTIONNAIRE

Tidewater Medical Center Greenbrier
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Phone: (757)389-5370
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Full Name	Age	Date & Place of Birth	Today's Date

Education	Age of Completion	Occupation	❑ Live by Self ❑ Marital Status _____ ❑ Live with Family ❑ # Children _____ ❑ Other (Specify)

Reason for Today's Visit ▶

PLEASE INDICATE ANY ILLNESS OR CONDITION THAT **YOU** HAVE HAD

❑ Diabetes	❑ Depression	❑ Liver Disease	❑ Arthritis	❑ STDs	❑ Asthma or COPD (Emphysema)
❑ High Blood Pressure	❑ Anxiety	❑ Migraines	❑ Gout	❑ IBS	❑ Eczema or Other Skin Disorders
❑ High Cholesterol	❑ Thyroid Disease	❑ Seizures	❑ Back Pain/Sciatica	❑ Alcoholism	❑ Cancer (Specify) _____
❑ Heart Disease	❑ GERD/Ulcers	❑ Cataracts	❑ Kidney Stones	❑ Tobacco Abuse	❑ Other _____
❑ Stroke	❑ Kidney Disease	❑ Glaucoma	❑ Recurrent UTI	❑ Drug Abuse	❑ Other _____

FAMILY HISTORY

Family Member	Diabetes	Cancer	Heart Disease	Stroke	High Blood Pressure	High Cholesterol	Asthma	Anxiety	Depression	Liver Disease	Kidney Disease	Other Please Indicate
Mother	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
Father	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
Sister	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
Brother	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
Son	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
Daughter	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	
Grandparent	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	

SURGICAL HISTORY

Type of Operation	Date

CURRENT MEDICATIONS - Both Prescription & Over The Counter

Name	Dosage	Name	Dosage

Continue On Back If Needed

VACCINES

Indicate disease against which you have been immunized

❑ Tetanus ❑ Pneumovax ❑ Meningitis ❑ Shingles

❑ Other (Describe) _____

Date of last known Tetanus shot _____

FEMALE HISTORY

LMP	
Number Of Pregnancies	
Contraception Used	❑ Yes ❑ No Type _____
Menstrual Problems	❑ Yes ❑ No
Last Pap Test	Date
Last Mammogram	Date
Last Bone Density Test	Date
Last Colonoscopy	Date
Any Abnormal Paps	❑ Yes ❑ No

MALE HISTORY

Last Prostate Check	Date
Last PSA Reading	Date
Last Colonoscopy	Date

MEDICATION ALLERGIES:

EXERCISE HABITS Walking Sports Other

SLEEP HABITS Bed Time Awake At

	YES	NO	Daily Amount
Do you currently use tobacco?	❑	❑	_____
Did you use tobacco in the past?	❑	❑	_____
Do you drink coffee or tea?	❑	❑	_____
Do you drink alcohol?	❑	❑	_____