Inova™

PSMHX

Date: _____

Personal Information:

Occupation: _____ Marital Status: _____ Name of Partner/Spouse: _____

Number of Children: _____ Children's Names/Age: _____

Race: ☐ Asian ☐ Black or African American ☐ Native American ☐ White/Caucasian ☐ Other: _____

Ethnicity: Do you identify with an ethnic origin? ☐ Yes ☐ No

If yes, describe: _____

Medical Care Team: List healthcare professionals involved in your medical care (e.g., medical doctor, psychiatrist/ psychologist, chiropractor, osteopathic doctor, physical therapist, occupational therapist, speech therapist, etc.)

Specialty	Provider	Specialty	Provider

Date of Last Complete Physical Exam: _____ Date of Last Bloodwork: _____

Date of Last Colonoscopy: _____ Date of Last Tetanus Shot: _____

Prescription or Over-the-Counter (OTC) Medications and Herbal Supplements: Indicate any prescriptions, OTC medications or herbal supplements which you have taken in the last week. Include dose and frequency.

Medication	Dose	Route	Frequency
Preferred Pharmacy:			

Allergies (include food & medication allergies): _____ Latex Allergy/Sensitivity: ☐ Yes ☐ No

_____ Adhesive Allergy/Sensitivity: ☐ Yes ☐ No

_____ Dog Allergy/Sensitivity: ☐ Yes ☐ No

_____

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Medical Condition & History

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH

☐ Outpatient Location: _____

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For Women:

First Day Of Last Menstrual Period: Date of Last Mammogram? Date of Last Dual-Energy X-Ray Absorptiometry (DEXA):	When was your last Pap Test? Was it normal? ☐ Yes ☐ No History of abnormal Pap Test? Date(s):
Number of Pregnancies: Miscarriages: Terminations: Living Children:	
Method(s) of Contraception:	

Family History: If you or a family member has had any of the following check yes and indicated which family member.

	Check Yes/No	Relation		Check Yes/No	Relation
1. Allergies/Hay Fever	☐ Yes ☐ No		12. High Blood Pressure	☐ Yes ☐ No	
2. Alcoholism	☐ Yes ☐ No		13. High Cholesterol	☐ Yes ☐ No	
3. Anemia	☐ Yes ☐ No		14. Kidney Disease	☐ Yes ☐ No	
4. Anxiety/Depression	☐ Yes ☐ No		15. Liver Disease	☐ Yes ☐ No	
5. Arthritis	☐ Yes ☐ No		16. Neurological Disease	☐ Yes ☐ No	
6. Asthma	☐ Yes ☐ No		17. Osteopenia/Osteoporosis	☐ Yes ☐ No	
7. Attention-Deficit/Hyperactivity Disorder (ADHD)	☐ Yes ☐ No		18. Seizure Disorder	☐ Yes ☐ No	
8.Blood Clots	☐ Yes ☐ No		19. Thyroid Disorder	☐ Yes ☐ No	
9. Cancer	☐ Yes ☐ No		20. Sexually Transmitted Infection	☐ Yes ☐ No	
10.Gynecological Disease	☐ Yes ☐ No		21. Other:	☐ Yes ☐ No	
11. Heart Attack	☐ Yes ☐ No		22. Other:	☐ Yes ☐ No	

Surgeries or Other Significant Conditions: Indicate any surgeries or other significant conditions for which you have been treated including fracture, dislocations, sprains. Include approximate date of injury.

Surgery/Condition	Date	Surgery/Condition	Date

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Social Information:

Tobacco Used:

Have you used tobacco products? ☐ Yes ☐ No

Specify: _____

How much do you use daily? _____

How many years? _____

If you no longer smoke, when did you quit? _____

Have you quit before? ☐ Yes ☐ No How long? _____

Do you use marijuana or any products that contain tetrahydrocannabinol (THC)? ☐ Yes ☐ No

If yes, what do you use and how much? _____

Illicit Drug Use:

☐ Yes ☐ No If yes, what do you use and how much? _____

Alcohol Use:

Do you drink alcohol? ☐ Yes ☐ No If so what type? _____ How many a week? _____

Diet:

Do you exercise? ☐ Yes ☐ No If so, what activities do you do, and how often in 1 week? _____

_____

Are you dieting? ☐ Yes ☐ No If so , What? _____

Do you consume caffeinated products? ☐ Yes ☐ No If so, what and how much per day? _____

_____

Have you recently noticed an increase in sadness or gloominess? ☐ Yes ☐ No

Have you lost interest in enjoyable activities? ☐ Yes ☐ No

Do you have a living will? ☐ Yes ☐ No

If yes, please provide us with a copy.

Patient (signature): _____ Date: _____ Time: _____

Interpreter Information (To be completed by Inova staff, if applicable):

☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) _____

☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

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Medical Condition & History

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