Inova Fairfax Hospital
Interventional Neuroradiology

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date:_____

Email: _____

Please list all of your present physicians:
Referring Physician

Name: _____

Address: _____

_____ Phone: _____

Physician 2 ☐ Check here if you would like us to send a summary of this consultation

Name: _____

Address: _____

_____ Phone: _____

Physician 3 ☐ Check here if you would like us to send a summary of this consultation

Name: _____

Address: _____

_____ Phone: _____

Please describe briefly the major problem which brings you here and when it began:

Please list any medications to which you have had an allergic reaction, including IODINE and Contrast Dye, and describe the allergic reaction:

Have you ever used tobacco? Yes_____ No_____ Years_____ Packs/Day_____

Are you still smoking?_____ When did you stop?_____

How many ounces of alcohol do you drink on an average? Day_____ Week_____

Please list all the medications and dosages that you are currently taking:

Drug	Dose	Frequency

Please list the operations that you have had:

Year	Type of Operation	Hospital	Surgeon

Please list your previous hospitalizations other than the operations listed above:

Year	Reason for Hospitalization	Hospital	Doctor

Please check any conditions or symptoms that you currently have or have had in the past.

- ☐ Diabetes
- ☐ Anemia
- ☐ Bleeding Disorders
- ☐ Rheumatic Fever
- ☐ Hepatitis
- ☐ Epilepsy/Seizures
- ☐ Headaches
- ☐ Blurred Vision
- ☐ Unusual Fatigue
- ☐ Soaking Sweats
- ☐ Lumps in Breasts
- ☐ Asthma
- ☐ High Blood Pressure
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Ankle Swelling
- ☐ Leg Pains when Walking
- ☐ Irregular Heart Beat
- ☐ Heart Murmurs
- ☐ Heart Attack
- ☐ Recent wt. Gain/Loss
- ☐ Difficulty Swallowing
- ☐ Nausea or Vomiting
- ☐ Change in Bowel Habits
- ☐ Blood in Stools
- ☐ Jaundice
- ☐ Kidney Trouble
- ☐ Arthritis
- ☐ Back/Bone Pain
- ☐ Enlarged Lymph Glands
- ☐ Myocardial Infarction
- ☐ Skin Tumors
- ☐ Chronic Cough