

**JAMES RIVER FAMILY PRACTICE, LLC
11835 FISHING POINT DR., SUITE 104
NEWPORT NEWS, VA 23606**

WELCOME TO OUR OFFICE Please provide us with the following information

Name: _____ Date of Birth: _____

ALL medical conditions for which you have been treated (as many as you can think of):

ALL allergies that you have (drug, food, latex, IV contrast dye, etc) **and the reaction:**

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

List ALL medications/OTC supplements/vitamins/herbals you take:

NAME	STRENGTH	HOW MANY TIMES TAKEN A DAY
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(CONTINUE ON BACK IF NECESSARY)

SURGERIES/PROCEDURES (include date, reason surgery was done, and side of body if applicable—right or left): _____

(CONTINUE ON BACK IF NECESSARY)

FAMILY HISTORY: List health conditions (cancer, heart problems, diabetes, depression, cancer, etc.). **(If deceased please include cause of death and age at which death occurred)**

Mother: _____

Father: _____

Sisters: (# of) ____ Health hx: _____

Brothers: (# of) ____ Health hx: _____

SOCIAL HISTORY:

Marital status: married single divorced widowed (circle) # of times married: _____

If married, what is Spouse/Significant Other's name _____

Who lives at home with you? _____

Children: Name and year born - _____

Hometown (where you grew up): _____ Military no roots (circle)

Military service: Branch _____ years of service: _____

Education (school, highest level of education, what did you study, when did you graduate?):

Hobbies/leisure time activities: _____

Exercise (type, days per week, etc.) _____

Employed: Y N or Retired (circle) What is/was your occupation? _____

Tobacco Use: (*includes vape and dip*): Never Previous Current (circle).

If previous, when did you quit? _____

If current smoker, how long have you smoked (years)? _____

How much do you smoke (packs/day)? _____

Interested in Quitting? _____

Alcohol: never rarely social daily (circle) type: _____

Have you ever used Street Drugs: Y or N (circle)

If yes, Past or Present (circle) and type: _____

GYNECOLOGIC: Date of last mammogram: _____ Normal? Y or N (circle)

Date of last pap smear date: _____ History of abnormal pap? Y or N (circle)

Date of last bone density study: _____

First day of last menstrual period or age of menopause: _____

Have you had a Colonoscopy? Y or N (circle) date: _____ normal/abnormal (circle)

When did you last have blood work completed? date: _____

Birth control: none IUD pills tubal condoms patch vasectomy (circle) other: _____

IMMUNIZATIONS: (please check off any immunizations you have received and the date rec'd)

Check this box if you don't know the information: []

Tetanus (Td or Tdap): _____

HPV (Gardasil): _____

Pneumovax 23 : _____

Meningitis: type A _____ type B _____

Pevnar 13: _____

Influenza (flu): _____

Zostavax (shingles) _____

Other Doctors/providers that you see: Eye: _____ OB/GYN: _____

Heart: _____ Skin: _____ Ortho: _____ GI: _____

Other (s): _____

Do you have an advanced directive: Y or N (circle) Name of your POA and phone number: _____

Code status (this is not a legal form, but will prompt more questions from your provider):

[] Full (do all possible including CPR) [] Do not attempt Resuscitation [] Do not Intubate

Preferred method of learning: Written (handout) Verbal (teaching session) Other (please specify): _____

Last Primary Care Provider:

Name: _____ Address: _____