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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(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_____
Prevnar 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:_____