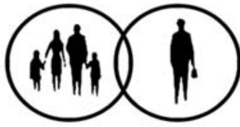

Chantilly Family Practice Center

Dr. Rajesh N. Mehra, Medical Director
4437 Brookfield Corporate Drive - Chantilly, VA 20151 - Office (703) 968 - 7277 Fax (703) 968 - 5644

MEDICAL HISTORY QUESTIONNAIRE

Name:	Date:
Address:	Date of Birth:

HAVE YOU NOW OR EVER HAD:

YES	NO		
❑	❑	1	Eye, ears, nose or throat problems?
❑	❑	2	Wear glasses or contact lentes?
❑	❑	3	High or low blood pressure?
❑	❑	4	Heart attacks, chest pain, heart disease or circulatory problems?
❑	❑	5	Blood clots or bleeding problems?
❑	❑	6	Breathing problems, asthma or emphysema?
❑	❑	7	Lung disease such as cancer or tuberculosis?
❑	❑	8	Kidney, bladder problems or kidney stones?
❑	❑	9	Diabetes, thyroid or gland problems?
❑	❑	10	Any unexplained weight gains or losses?
❑	❑	11	Problems with your skin, such as rashes, sores or eruptions?
❑	❑	12	Muscle, bone, joint or tendon problems?
❑	❑	13	Arthritis, rheumatism, paralysis or muscle weakness?
❑	❑	14	Epilepsy, fainting spells, convulsions or blackouts?
❑	❑	15	Dislocated vertebras, slipped discs or back problems?
❑	❑	16	Hernias, strains or ruptures?
❑	❑	17	Head injuries or loss on consciousness?
❑	❑	18	Surgery for other than cosmetic or plastic surgery reasons?
❑	❑	19	Lacerated tendons or nerves?
❑	❑	20	Hospitalized because of injury or illness?
❑	❑	21	Highly infectious diseases such as mononucleosis or hepatitis?
❑	❑	22	Lost more than 10 or more days of work due to injury or illness?
❑	❑	23	Any physical problems that may affect your ability to do the job you are applying for?

*If you answered **YES** to any questions above, please explain:

number	

I certify that to the best of my knowledge, I have answered all questions pertaining to my medical history truthfully, and understand giving false information may lead to dismissal from the job I am applying for.

Signature ____________________ Date ____________________

Form AR-005B