Chingchai Wanidworanun, MD, PLLC (Arlington Office and Silver Spring Office)
4001 9th Street North, Suite 228, Arlington, Virginia 22203 & 3901 Randolph Road Silver Spring, Maryland 20902
(703) 387-0999, (301) 949-4994. Fax: (703) 387-0911. www.DrWanid.com

Patient Name_____ Date of Birth_____
For Patients less than 18 years old, please have parent fill out and sign form.

PAST MEDICAL HISTORY
Have you ever had any of the following conditions? Circle Yes/No.
Are they still active problems? Circle "A" for active, "I" for inactive.

1. Unexplained weight change------Yes No, "A" "I".
2. Diabetes----------Yes No, "A" "I".
3. Cancer----------Yes No, "A" "I".
4. Thyroid disease----------Yes No, "A" "I".
5. HIV----------Yes No, "A" "I".
6. High blood pressure----------Yes No, "A" "I".
7. Stroke----------Yes No, "A" "I".
8. Heart disease----------Yes No, "A" "I".
9. Chest Pain/Tightness----------Yes No, "A" "I".
10. Palpitations----------Yes No, "A" "I".
11. Lightheadedness----------Yes No, "A" "I".
12. Swollen ankles----------Yes No, "A" "I".
13. Rheumatic fever----------Yes No, "A" "I".
14. Shortness of breath----------Yes No, "A" "I".
15. Asthma----------Yes No, "A" "I".
16. Bronchitis/emphysema----------Yes No, "A" "I".
17. Pneumonia----------Yes No, "A" "I".
18. Persistent cough----------Yes No, "A" "I".
19. TB----------Yes No, "A" "I".
20. Hay fever/sinusitis----------Yes No, "A" "I".
21. Ulcers/heartburn----------Yes No, "A" "I".
22. Indigestion----------Yes No, "A" "I".
23. Change in stools----------Yes No, "A" "I".
24. Blood in stool----------Yes No, "A" "I".
25. Constipation----------Yes No, "A" "I".
26. Hemorrhoid ----------Yes No, "A" "I".
27. Colitis/Crohn Disease-------Yes No, "A" "I".
28. Hepatitis or jaundice --------Yes No, "A" "I".
29. Gall bladder disease --------Yes No, "A" "I".
30. Pancreatitis----------Yes No, "A" "I".
31. Low libido----------Yes No, "A" "I".
32. Sexual problem----------Yes No, "A" "I".
33. Kidney diseases----------Yes No, "A" "I".
34. Kidney stones----------Yes No, "A" "I".
35. Urination problem----------Yes No, "A" "I".
36. Prostate problem----------Yes No, "A" "I".
37. Arthritis----------Yes No, "A" "I".
38. Head and neck radiation----Yes No, "A" "I".
39. Skin diseases----------Yes No, "A" "I".
40. Blood disorders----------Yes No, "A" "I".
41. Venereal diseases/STD-----Yes No, "A" "I".
42. Headache----------Yes No, "A" "I".
43. Low back pain----------Yes No, "A" "I".
44. Gout----------Yes No, "A" "I".
45. Anxiety----------Yes No, "A" "I".
46. Manic/Depression----------Yes No, "A" "I".
47. Eating disorder----------Yes No, "A" "I".
48. Alcohol abuse----------Yes No, "A" "I".
49. Drug abuse----------Yes No, "A" "I".
50. Attention deficit----------Yes No, "A" "I".
51. Seizure/epilepsy----------Yes No, "A" "I".

Others_____.

Gynecologic History: 52. Age of your first menstruation___. 53. Abnormal Menstruation? Yes No.
54. Abnormal PAP/mammogram? Yes No, "A" "I". 55. Abnormal vaginal discharge? Yes No, "A" "I".
56. How many pregnancies in the past? ___ . 57. How many miscarriages? ___. 58. Menopause? Yes No.

59.Prior major illnesses, psychiatric illnesses, injuries - dates:_____
_____
60.Prior hospitalizations - dates:_____
_____
61.PRIOR SURGERIES - dates:_____
62.MEDICATIONS, vitamins, supplements, herbals_____
_____
63.ALLERGIES to drugs, X-ray dyes, or other substances? Yes No. _____
_____

Genetic FAMILY HISTORY:
64. Genetic family history is Known/Unknown. Explain (adopted, etc)_____
Does any one in your genetic family (genetic parents, grandparents and/or siblings) have any of the following conditions? Who has it? And at what age was it diagnosed?
65. Diabetes Mellitus ? Yes No. _____
66. Heart Attack ? Yes No. _____
67. Heart Disease ? Yes No. _____
68. Hypertension ? Yes No. _____
69. Stroke ? Yes No. _____

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Genetic FAMILY HISTORY continued:

70. Cancer ? Yes No. _____
71. Mental Illness ? Yes No. _____
72. Drug /Alcohol Addiction ? Yes No. _____
73. Bleeding Disease ? Yes No. _____
74. Glaucoma ? Yes No. _____
75. Arthritis ? Yes No. _____
75. Hepatitis, HIV, TB ? Yes No. _____
76. Other ? Yes No. _____

TOBACCO

77. Do you smoke? Yes No. 78. Smoke cigarettes/cigars ____ pack per day for past ____ years.
79. Used to smoke cigarettes/cigars ___ pack per day for ___ years. Quit smoking in _____.
80. Use recreational drugs? Yes No. Describe_____.

ALCOHOL

81. Do you drink alcoholic beverages? Yes No. How much per week?_____.

INTERVENTION

82. Routine childhood vaccination (MMR, polio, DPT) completed? Yes No.
83. Do you exercise regularly? Yes No. Describe_____.
84. Do you have a physical disability? Yes No Describe_____.
85. Do you use a seatbelt while driving/riding in a car? Yes No. _____.

SOCIAL HISTORY:

86. Occupation/Job? Yes No. 86. Work as _____at _____.
87. Retired from _____. 88. Homemaker? Yes No.
89. Student at _____ What year?_____.
90. Level of education_____ .
91. Would you like to tell us about your religious and cultural backgrounds that may be pertinent to your medical needs? Yes No. Describe_____.
92. Would you like to tell us about your sexual practice/sexual orientation that may be pertinent to your medical needs? Yes No. Describe_____.
93. Do you have a living will or advanced directives? Yes No. If no, would you be interested in more information? Yes No.

MARITAL HISTORY:

93. Have spouse/partner? Yes No. Years having been together with current spouse/partner __.
His or her name:_____ . Age:___. Occupation:_____.
94. Do you have children? Yes No. Number of son (s)__, daughter(s)__.
95. Living alone? Yes No. Living with _____.
96. Do you feel safe at home? Yes No. Describe_____.

Patient Name_____ Date of Birth_____
For Patients less than 18 years old, please have parent fill and sign form.
Parent name_____

Patient/Parent Signature_____ Date_____

Address:_____

Phone/email:_____

How did you hear about the doctor?_____