MARGARET GRADZKA, M.D, F.A.C.R

3620 JOSEPH SIEWICK DRIVE, SUITE #401
FAIRFAX, VIRGINIA 22033-1744

TELEPHONE: 703-648-9800
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PATIENT MEDICAL HISTORY DESCRIPTION

Patient Name:			**Date:**
Primary Physician:		**Referring Physician:**	
Height		**Weight:**	

Please list all allergies to medication.

Please describe your medical history ***(for example, high blood pressure, Diabetes, Malaria, etc.)***

Please describe your Hospital and Surgical history.

Please describe your Family's Medical History ***(for example, Cancer, Diabetes, etc.)***

Mother:	**Father:**
Brother(s):	**Sister(s):**
Maternal Grandparents:	**Paternal Grandparents:**

Please describe your Social History

Marital Status:		**Number of Children:**	**Occupation:**
Do you Smoke?	**YES** ☐ **NO** ☐	**Describe your use of Alcohol**	
How frequently do you exercise?		**Have you ever had a blood transfusion? YES** ☐ **NO** ☐	
Have you ever used Illegal Drugs? ***(for example, Heroin, Marijuana, Cocaine, etc.)*** **YES** ☐ **NO** ☐			

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PATIENT MEDICATION HISTORY

Please list all medications you are currently taking

Medication	Dosage	How Often?