

Medical History Form

Please bring this completed form to your first appointment.

Patient Name		Date
Name of Personal Physician		
Physician's Address: Street		City
State	Zip Code	Telephone

1. Please indicate any illnesses for which you are currently being treated and the nature of the treatment.
2. Please list any major illnesses for which you have been treated in the past.
3. List any medications which you take, as well as the dosage.
4. Please list any allergies.
5. Give the date of your last complete physical which included blood tests. Please have test results sent to Arlington Psychiatric Group if done in the last six months.
6. If you are being treated by any specialists, list their names, addresses, and phone numbers.

Arlington Psychiatric Group, P.C.

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