Mary Washington Medical Group
Virginia Cardiovascular and Thoracic Surgery

1101 Sam Perry Blvd, Suite 211
Fredericksburg, VA 22401
Phone: 540.372.7792 | Fax: 540.372.2073
practices.mwhc.com

Surgeon: J. Timothy Sherwood, MD

Patient Name: _____ Date of Birth: _____ / _____ / _____

Occupation: _____ Presently Working: _____ Retired: _____ Disabled: _____

Reason for Visit: _____

Current Living Situation

- ❑ Lives alone
- ❑ Lives with spouse/partner
- ❑ Lives with adult child or other relative
- ❑ Lives in Assisted Living Facility
- ❑ Lives in Nursing Home

Functional Status with Activities of Daily Living

- ❑ Independent (requires no assistance)
- ❑ Partially Dependent (requires some assistance)
- ❑ Totally Dependent (requires total assistance)

Describe Your Exercise Tolerance:

- ❑ Bedridden
- ❑ Able to walk with assistance
- ❑ Limited (Less than 1 flight of stairs)
- ❑ Moderate (1-2 flights of stairs or comparable)
- ❑ Active (Over 2 flights of stairs or comparable with ease)

Regarding Your Diet:

- ❑ Recent weight loss: If so, how much? _____
- ❑ Recent weight gain: If so, how much? _____
- ❑ Special diet: Specify: _____
- ❑ Difficulty swallowing

Medical History *(Check All That Apply)*

Heart Disease:

- ❑ High Blood Pressure
- ❑ Chest Pain
- ❑ Heart Attack
- ❑ Heart Surgery
- ❑ Heart Rhythm Problems or Palpitations
- ❑ Heart Valve Problems
- ❑ Congestive Heart Failure
- ❑ Pulmonary Fibrosis

Lung Disease:

- ❑ Asthma / Wheezing
- ❑ Bronchitis
- ❑ Emphysema / COPD
- ❑ Interstitial Lung Disease / Pulmonary Fibrosis
- ❑ Cystic Fibrosis
- ❑ Sleep Apnea
- ❑ Tuberculosis
- ❑ Coughing up blood

Heart Testing (Completed or Pending)

Electrocardiogram (EKG)	Date: ____ / ____ / ____	Dr. _____
Echocardiogram	Date: ____ / ____ / ____	Dr. _____
Stress Test	Date: ____ / ____ / ____	Dr. _____
Cardiac Catheterization:	Date: ____ / ____ / ____	Dr. _____

Regarding Lung Problems, Have You:

Been on Steroids within 2 years?	When: _____	Prescribed by: _____
Been on Antibiotics within 6 weeks?	When: _____	Prescribed by: _____
Been seen in the ER within 2 years?	When: _____	Where: _____
Been in Hospital in past 2 years?	When: _____	Where: _____
Had a Chest X-ray in past 6 months?	When: _____	Where: _____
Undergone Breathing Tests?	When: _____	Where: _____

Other: _____

_____

Medical History *(Check All That Apply)*

Other Medical Conditions

- ❑ Kidney Disease: Dialysis? _____
- ❑ Bladder / Urinary Disorder
- ❑ Adrenal Disease
- ❑ Liver Disease: Specify:_____
- ❑ Excessive Bleeding
- ❑ Blood Clots
- ❑ Sickle Cell
- ❑ GERD / Hiatal Hernia
- ❑ Cancer: Type?_____
- ❑ Recent Cold or Flu (Within 3 months)
- ❑ Stomach Ulcers
- ❑ Diabetes: Controlled By: _____
- ❑ Thyroid
- ❑ Arthritis
- ❑ Fainting / Dizzy Spells
- ❑ Neurologic Disease: Specify: _____
- ❑ Stroke
- ❑ Back Problems

Additional Medical History:

_____

_____

_____

Past Surgical History:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please bring a copy of medications and allergies to your appointment for review.

Smoking/Alcohol History:

- ❑ Have you ever smoked? Yes _____ No _____
- ❑ Cigarettes
- ❑ E-Cigarette / Vape
- ❑ Cigars
- ❑ Pipe
- ❑ Snuff / Chew

Are you currently smoking? Yes _____ No _____
Start date: _____
Quit date:_____
How many per day? _____
How many years? _____

Do you drink alcohol? Yes _____ No _____

If yes,_____drinks per day_____ drinks per week

Do you use any illicit drugs? Yes _____ No _____
If so, What? _____

Travel/Occupation

What type of work do or did you do? _____
Where have you traveled within the United States and other countries? _____
Have you ever had any exposures to chemicals or elements such as asbestos? _____

Family History

Mother: Cancer? Yes _____ No _____ Other Illness(es): _____
Father: Cancer? Yes _____ No _____ Other Illness(es): _____
Siblings: Cancer? Yes _____ No _____ Other Illness(es): _____

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Other Providers

Primary Care:

Name:_____

Address:_____ City:_____

State: _____ Zip:_____

Pulmonologist:

Name:_____

Address:_____ City:_____

State: _____ Zip:_____

Oncologist:

Name:_____

Address:_____ City:_____

State: _____ Zip:_____

Gastroenterologist:

Name:_____

Address:_____ City:_____

State: _____ Zip:_____

Cardiologist:

Name:_____

Address:_____ City:_____

State: _____ Zip:_____

Other:

Name:_____

Address:_____ City:_____

State: _____ Zip:_____