513 W Broad St, Suite 100
Falls Church, Virginia 22046

# New Patient Medical History Form



Name: ________________________ Date of Birth: ___________________ Today's date: ____________

**Present Health Concerns**:

***Allergies* to Medication, Food, or Other Agent** | ***Reaction/Side Effect***

1.______________________________________ ________________________________________
2.______________________________________ ________________________________________
3.______________________________________ ________________________________________

**Medications** (prescriptions [include birth control pills, vitamins, and supplements]

| *Name* | *Unit size of dose* | *Number of units at once* | *Route (oral, ocular, injection, etc.)* | *Doses/day* |
|---|---|---|---|---|
| (e.g., Lasix | 40 mg. | 2 pills | oral | 1x/day |
| Lantus insulin | 22 units | - | injection | 2x/day |
| Cosopt | 2 drops | - | left eye | 5x/day) |

1.________________________________________________________________________________________
2.________________________________________________________________________________________
3.________________________________________________________________________________________
4.________________________________________________________________________________________
5.________________________________________________________________________________________
6.________________________________________________________________________________________

**Personal History**:

| *Condition* | *Date of Diagnosis* | *Any Comment* |
|---|---|---|
| Arthritis | | |
| Cancer(breast/cervical/colorectal/lung/prostate/skin/_______) | _______________ | ___________ |
| Cerebral Infarct ("stroke") | _______________ | ___________ |
| Coronary Artery disease (angina/heart trouble/heart attack) | _______________ | ___________ |
| Diabetes mellitus (I or II) | _______________ | ___________ |
| Gastrointestinal Disease (Crohn's/esophageal reflux/ | _______________ | ___________ |
| Gastric or duodenal ulcers/Ulcerative colitis/Other _________ | _______________ | ___________ |
| Glaucoma | _______________ | ___________ |
| High Blood Pressure/Hypertension | _______________ | ___________ |
| High Cholesterol/Hypercholesterolemia | _______________ | ___________ |
| Liver Disease | _______________ | ___________ |
| Lung Disease | _______________ | ___________ |
| Venereal Disease (chlamydia/gonorrhea/H. simplex/HIV[AIDS]/syphilis) | _______________ | ___________ |
| Other | _______________ | ___________ |

**Surgical History/Procedures** (e.g., appendix, joint, gall bladder, hemorrhoidectomy, hernia, hysterectomy, LASIK, lens replacements (cataract surgery), tonsils, etc.)

| *Name of Procedure* | *Date* | *Any Comment* |
|---|---|---|
| 1.______________________________ | ___________ | ________________________________________ |
| 2. .______________________________ | ___________ | ________________________________________ |
| 3. .______________________________ | ___________ | ________________________________________ |
| 4. .______________________________ | ___________ | ________________________________________ |
| 5. .______________________________ | ___________ | ________________________________________ |

Name: ________________________ Date of Birth: ___________________ Today's date: ____________

**Family History**:

| *Relationship to Patient* | *Illnesses/Cause of death* | *Relevant Examples* |
|---|---|---|
| Father (alive - current age ____) | | Cancer, breast |
| (deceased - age at death____) | _____________________ | Cancer, colorectal |
| | | Cancer, lung |
| Mother (alive - current age ____) | | Cancer, prostate or other |
| (deceased - age at death____) | _____________________ | Diabetes Mellitus (I/II) |
| | | Heart Disease (Blocked Artery/ Heart Attack/Pacemaker) |
| Brothers, number of ____ | _____________________ | High Blood Pressure/Hypertension |
| | | High Cholesterol |
| Sisters, number of _____ | _____________________ | Mental Health Issues |
| | | Anxiety/Depression/ |
| Children, number of ____ | _____________________ | Substance Abuse[Alcohol/Cocaine /Marijuana/Narcotics/Nicotine] |
| | | Stroke /Cerebral Infarct/Hemorrhage |

**Social History**:

Marital Status: Single Married Separated Divorced Widowed

Work Status: Student (if so, grade/level) ____ Employed outside of house (if so, occupation) ______________
Employed within house Between jobs Retired

Tobacco Use: Current (if so, how many cigarettes/day?) ____ and (what year did you start?) ________
Former (if so, how many years ____ and how many packs per day? ____ ) Never smoked

Alcohol Use: How many beers/glasses of wine/other spirits per week? ________
Has your alcohol use ever been an issue to you or others? Yes / No

Recent or Current Non-prescription Substance Use: Cocaine (including "crack") Injectables LSD Marijuana
Meth-amphetamine Narcotics Other ___________

Do you identify yourself as male/female/transg m/trang f/genderqueer/other? M / F / Tm / Tf / Gqr / Other
Is your sexual orientation heterosexual/homosexual/bisexual/asexual/other? He / Ho / Bi / As / Other
If sexually active, are you careful to avoid STD's and unwanted pregnancy? Yes / No / Not Applicable
How many days/week do you exercise (i.e., get your heart to 85% of predict max heart rate)? 0/1/2/3/4/5/6/7

**Personal Safety**:

CO (carbon monoxide) Detector – how many detector(s) do you have at home?: 0/1/2/___
Fire Detectors – how many do you have at home? ___ Do you check the batteries twice yearly? Y / N
Gun Ownership – if you have a gun at home, is it properly secured? Yes / No / Not Applicable
Seat Belts – do you use your seatbelts 100% while in a car: Y / N

**Health Maintenance:**

Colonoscopy – when was your last? ____ (Year)/None.
Dental Care – when was your last? ___/___ (Month/Year)/None.
Eye Care – when was your last? ____ (Year)/None.
Mammogram (if female) – when was your last? ____ (Year)/None.
Pap smear (if female) – when was your last? ____(Year)/None.

Vaccines-are you current? (Y / N / Unknown / NA)
Flu ____ Pneumovax _____ Tetanus _____
Zostavax/Shingles ______Others _______