

Sarah Fletcher, MD
 Elizabeth Zapp, MD
 Cynthia Yew, FNP-BC
 Jessica Scalzo, FNP-BC



21135 Whitfield Place
 Suite 107
 Phone: (703) 421-7000
 Fax: (703) 430-4830

www.sterlingfamilypractice.com

Please take a moment to fill out this medical history form so that your practitioner can get better acquainted with your medical history. We realize that not all of the questions may pertain to you, but please answer all questions that apply. Thank you.

Patient's Full Name: _____ Date of Birth: _____

Today's Date: _____ Height: _____ Weight: _____ Blood Type: A B AB O+ O-

Primary Care Doctor: _____ Referring Doctor: _____

Reason for Visit: _____

Preferred Pharmacy Name: _____ Pharmacy Address: _____

Pharmacy Phone Number: _____ Pharmacy Fax Number: _____

Allergies: (List all medications, food and environmental)

Medications: (List all current medications including vitamins & supplements)

<i>Date started</i>	<i>Medication & Dose</i>	<i>Directions</i>	<i>Reason for Taking</i>	<i>Prescribed by</i>

Past Medical History: (Please check all that apply)

<input type="checkbox"/> Attention Deficit Disorder	<input type="checkbox"/> Dizziness/Vertigo	<input type="checkbox"/> Headache	<input type="checkbox"/> Leukemia
<input type="checkbox"/> Anemia	<input type="checkbox"/> Depression	<input type="checkbox"/> Herpes	<input type="checkbox"/> Migraine Headache
<input type="checkbox"/> Asthma	<input type="checkbox"/> Easy Bleeding	<input type="checkbox"/> HIV Infection	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Alcohol Disorder	<input type="checkbox"/> Eczema	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Esophageal Reflux	<input type="checkbox"/> Hodgkin's Disease	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Cancer	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Concussion	<input type="checkbox"/> Gastrointestinal Disorder	<input type="checkbox"/> Lupus	<input type="checkbox"/> Stroke Syndrome
<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Lyme Disease	<input type="checkbox"/> Thyroid Disorder

Please list any other past medical history:

Past Surgical History: (Please check all that apply and include the date)

<i>Surgery</i>	<i>Date</i>	<i>Surgery</i>	<i>Date</i>	<i>Surgery</i>	<i>Date</i>
<input type="checkbox"/> Appendectomy		<input type="checkbox"/> Hernia Repair		<input type="checkbox"/> Shoulder Surgery	
<input type="checkbox"/> Back Surgery		<input type="checkbox"/> Hysterectomy		<input type="checkbox"/> Sinus Surgery	
<input type="checkbox"/> Breast Surgery		<input type="checkbox"/> Hip Surgery		<input type="checkbox"/> Tonsillectomy	
<input type="checkbox"/> Cataract Surgery		<input type="checkbox"/> Knee Surgery		<input type="checkbox"/> Thyroid Surgery	
<input type="checkbox"/> C-Section		<input type="checkbox"/> Laparoscopy		<input type="checkbox"/> Vasectomy	
<input type="checkbox"/> Colonoscopy		<input type="checkbox"/> Pacemaker Placement		<input type="checkbox"/> Wisdom Teeth	
<input type="checkbox"/> Cosmetic Surgery		<input type="checkbox"/> Prostate Surgery		<input type="checkbox"/> Other: _____	

Family History: (Please check all that apply)

	Father	Mother	Brother	Sister	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother
Alcoholism								
Asthma								
Bleeding disorder								
Cancer								
Deceased								
Depression								
Diabetes								
Drug Abuse								
Epilepsy								
Heart Disease								
High Blood Pressure								
High Cholesterol								
Migraines								
Stroke								
Suicide								
Thyroid Problems								

Please list any other family medical history:

Prevention Information:

	<i>Yes</i>	<i>No</i>		<i>Yes</i>	<i>No</i>
Do you use seat belts?			Do you have a living will?		
Do you have smoke detectors in your home?			Do you practice a healthy diet?		
Do you have a loaded firearm in your home? If yes, how is it stored?					
Do you use sunscreen?					

Please list any vaccine history:

Social/Lifestyle History:

Marital Status: Single Married Widowed Divorced Separated

If married, spouse's name: _____

Children(s) names and age(s): _____

What is your occupation: _____

What are your hobbies: _____

Do you exercise regularly: _____

Who lives at home with you: _____

Where were you born and raised: _____

How long have you been in this area: _____

Do you drive an automobile: _____ Do you ride a motorcycle/bicycle: _____

Do you wear a helmet: _____

Do you currently smoke or use nicotine products: _____ If yes, for how many years: _____

Are you a former smoker: _____ If yes, when did you quit: _____

Cigarettes (# Packs/day): _____ Cigars: _____ Pipe: _____ Chew Tobacco: _____

Have you ever used recreational drugs: _____ If yes, when was the last time: _____

What kind did you use: _____

Do you take over-the-counter medication such as aspirin, antacids, vitamins, herbal products: _____

If yes, which ones and how often: _____

Do you take something to help you sleep: _____ If yes, what and how often: _____

Do you restrict your diet in any way: _____ If yes, how: _____

Do you drink alcohol: Never Occasionally Daily

If yes, how many days per week do you drink alcohol: _____

On a typical day when you drink, how many drinks do you have: _____

Do you drink caffeine: _____ If yes, how much: _____

Ever worked with chemicals, paints, asbestos, or any hazardous material?: _____

If yes, what kind: _____

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Review of Symptoms

Patient's Full Name: _____ Date of Birth: _____ Today's Date: _____

Please check all that apply.

Male Female Medication allergies: Yes No

Please check any symptoms you are experiencing today.

Systemic Symptoms	<input type="checkbox"/> fatigue <input type="checkbox"/> fever/chills <input type="checkbox"/> weight change
Head Related	<input type="checkbox"/> headache <input type="checkbox"/> facial pain
Eye	<input type="checkbox"/> trouble with vision <input type="checkbox"/> pain <input type="checkbox"/> redness <input type="checkbox"/> light sensitivity
Ear-Nose-Throat-Mouth	<input type="checkbox"/> earache <input type="checkbox"/> pressure <input type="checkbox"/> ringing <input type="checkbox"/> TMJ <input type="checkbox"/> runny nose <input type="checkbox"/> nose bleeds <input type="checkbox"/> post nasal drip <input type="checkbox"/> sneezing <input type="checkbox"/> snoring <input type="checkbox"/> sore throat <input type="checkbox"/> itchy throat <input type="checkbox"/> hoarseness <input type="checkbox"/> mouth sores <input type="checkbox"/> dryness <input type="checkbox"/> trouble swallowing
Neck	<input type="checkbox"/> swollen glands <input type="checkbox"/> pain <input type="checkbox"/> muscle tightness
Respiratory	<input type="checkbox"/> cough <input type="checkbox"/> wheezing <input type="checkbox"/> shortness of breath
Cardiovascular	<input type="checkbox"/> chest pain <input type="checkbox"/> palpitations <input type="checkbox"/> irregular heart rate <input type="checkbox"/> edema <input type="checkbox"/> fast heart rate
Gastrointestinal	<input type="checkbox"/> abdominal pain <input type="checkbox"/> heart burn <input type="checkbox"/> nausea <input type="checkbox"/> vomiting <input type="checkbox"/> diarrhea <input type="checkbox"/> constipation <input type="checkbox"/> blood in stool <input type="checkbox"/> change of bowel habits
Urinary	<input type="checkbox"/> pain <input type="checkbox"/> frequency <input type="checkbox"/> blood in urine
Skin	<input type="checkbox"/> rash <input type="checkbox"/> lesions <input type="checkbox"/> abnormal hair loss
Musculoskeletal	<input type="checkbox"/> joint pain <input type="checkbox"/> back pain <input type="checkbox"/> muscle pain <input type="checkbox"/> restless legs
Neurological	<input type="checkbox"/> fainting <input type="checkbox"/> numbness <input type="checkbox"/> dizziness
Psychological	<input type="checkbox"/> insomnia <input type="checkbox"/> depression <input type="checkbox"/> anxious <input type="checkbox"/> irritable <input type="checkbox"/> generally not having fun in life
Male	<input type="checkbox"/> slow urine flow <input type="checkbox"/> low libido <input type="checkbox"/> erectile dysfunction
Female	<input type="checkbox"/> pelvic pain <input type="checkbox"/> PMS <input type="checkbox"/> vaginal discharge <input type="checkbox"/> abnormal bleeding Date of last period: _____ Date of last pap: _____ Period last ____ days Period comes every ____ days # of pregnancies _____ # of births _____ Current method of birth control _____
Date of last tetanus shot	_____

Other additional comments:
