21135 Whitfield Place, Suite 107, Sterling, VA 20165
Phone: (703) 421-7000
Fax: (703) 430-4830

Full Name:	Date of Birth:	Date:

Primary Care Doctor:_____ Referring Doctor:_____

Reason for Visit:_____

Preferred Pharmacy (Name and City):_____ Pharmacy Phone number:_____

Allergies: (List all medications, food and environmental)

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

Date started	Medication & Dose	Directions	Reason for Taking	Prescribed by

Past Medical History (Please check any past medical history and/or list any past medical history under other)

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

Full Name:	Date of Birth:	Date:

Past Surgical History (Please check any past surgical history and date of occurrence)

Name	Date	Name	Date	Name	Date
☐ Appendectomy		☐ Hysterectomy		☐ Tonsillectomy	
☐ Back Surgery		☐ Hip Surgery		☐ Thyroid Surgery	
☐ Breast Surgery		☐ Knee Surgery		☐ Vasectomy	
☐ Cataract Surgery		☐ Laparoscopy		☐ Wisdom Teeth	
☐ C-Section		☐ Pacemaker Placement		☐ Other	
☐ Colonoscopy		☐ Prostate Surgery		☐ Other	
☐ Cosmetic Surgery		☐ Shoulder Surgery		☐ Other	
☐ Hernia Repair		☐ Sinus Surgery		☐ Other	
☐ Other		☐ Other		☐ Other	

Family History (Please circle any that apply)

	Family Hx	Father	Mother	Brother	Sister	PGF	PGM	MGF	MGM	Son	Daughter
Alcoholism	Y / N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Asthma	Y / N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Bleeding disorder	Y / N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Cancer	Y / N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Depression	Y / N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Diabetes	Y / N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Epilepsy	Y / N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Heart Disease	Y / N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
High Blood Pressure	Y / N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
High Cholesterol	Y / N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Migraines	Y / N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Stroke	Y / N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Thyroid Problems	Y / N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Deceased											

Please list any other family medical history.

_____

Full Name:	Date of Birth:	Date:

Social History: (Please check yes or no and fill out the appropriate information)

Marital status:	Occupation:	Do you currently smoke? ☐Yes ☐No	Were you a former smoker? ☐Yes ___No☐
How much per day do you smoke?	What do you smoke? (ie cigars)	Do you drink alcohol? ___Yes ___No	How much alcohol do you consume? ___Week ___Month
Do you drink caffeine? _____Yes _____No	How much caffeine?	Ever worked with chemicals, paints, asbestos, or any hazardous material? ☐Yes ☐No	If yes, what kind?
Do you use sunscreen? ___Yes ____No	Do you use a seatbelt? ___Yes ____No	Do you wear a helmet? ____Yes ____No	Do you exercise regularly? ____Yes ____No
Do you use recreational drugs? ☐Yes ☐No	Have you ever used recreational drugs? ☐Yes ☐No	Do you follow a healthy diet? ___Yes ___No ____Room to Improve	
Do you have a living will? ☐Yes ☐No	Any other comments?		