



DR. LINDA COLEMAN & ASSOCIATES

*Primary Care*

Phone: 703-430-7090 | Fax: 703-444-98782 | 2 Pidgeon Hill Drive, Suite 400, Sterling, VA 20165

**MEDICAL HISTORY**

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.

If you are new to this clinic, who was your previous primary care physician? \_\_\_\_\_

Patient's Full Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Type: \_\_\_\_\_

**MEDICATION LIST**

Date Started	Medication and Dose	Directions	Date Stopped	Reason for Taking	Prescribed By

**PAST MEDICAL HISTORY**

1. Please list any active medical problems for which you are currently being treated, such as hypertension, diabetes, high cholesterol, asthma, and seizures.

\_\_\_\_\_

2. Please list your surgeries with the date(s)

\_\_\_\_\_

3. Please list your non-surgical hospitalizations with the date(s)

\_\_\_\_\_

4. Please list any major accidents or injuries with the date(s)

\_\_\_\_\_

\_\_\_\_\_

**PREVENTION INFORMATION**

Have you ever had (and date):

Flu Vaccine \_\_\_\_\_ Hepatitis B Vaccine \_\_\_\_\_ Pneumonia Vaccine \_\_\_\_\_  
Hepatitis A Vaccine \_\_\_\_\_ Tetanus Vaccine \_\_\_\_\_ Gardasil Vaccine \_\_\_\_\_  
Meningitis Vaccine \_\_\_\_\_ PPD/TB Test \_\_\_\_\_

Do you use seat belts? Yes No  
Do you have smoke detectors in your home? Yes No  
Do you have a loaded firearm in your home? Yes No If yes, how is it stored? \_\_\_\_\_

**SOCIAL HISTORY/LIFESTYLE**

Where were you born and raised? \_\_\_\_\_ How long have you been in this area? \_\_\_\_\_

Do you still drive an automobile? Yes No  
Marital Status: Single Married Widowed Divorced Separated  
If married, spouse's name \_\_\_\_\_ Children(s) names and ages \_\_\_\_\_

Who lives at home with you? \_\_\_\_\_

Occupation \_\_\_\_\_ Hobbies \_\_\_\_\_

Do you ride a motorcycle/bicycle? Yes No Do you wear a helmet? Yes No  
Do you smoke or use nicotine products? Yes No How many years? \_\_\_\_\_

Cigarettes (# Packs/day) \_\_\_\_\_ Cigars \_\_\_\_\_ Pipe \_\_\_\_\_ Chew Tobacco \_\_\_\_\_  
Have you ever used recreational drugs? Yes No 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? Yes No  
If yes, which ones and how often? \_\_\_\_\_

Do you take something to help you sleep? Yes No If yes, what and how often? \_\_\_\_\_

Do you restrict your diet in any way? Yes No 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? Yes No If yes, how much? \_\_\_\_\_

Ever worked with chemicals, paints, asbestos, or any hazardous material? Yes No  
If yes, what kind? \_\_\_\_\_

**FAMILY HISTORY**

How many children do you have? None Sons \_\_\_\_\_ Daughters \_\_\_\_\_

Are all alive and in good health? Yes No If no, please explain \_\_\_\_\_

How many siblings do you have? None Brothers \_\_\_\_\_ Sisters \_\_\_\_\_

Are they alive and well? Yes No If no, please explain \_\_\_\_\_

Is your mother still living? Yes No If yes, major health problems / if no, cause of death \_\_\_\_\_

Is your father still living? Yes No If yes, major health problems / if no, cause of death \_\_\_\_\_

Is there a family history - father, mother, sister, brother, maternal/paternal grandparents of:

Relative	Diabetes	Alcoholism	Drug Abuse	High Cholesterol	Suicide	Depression	Cancer (type)
Father							
Mother							
Sibling							
M. Grandmother							
M. Grandfather							
P. Grandmother							
P. Grandfather							
Other							

**SYSTEMS REVIEW**

**General -** Have you noticed:

Significant weight change (>10 lbs) in the past 6 months? No Yes, Increase \_\_\_\_\_ lbs. Decrease \_\_\_\_\_ lbs.

Significant recent appetite change? Yes No If yes, Increase Decrease

Significant sweating or night sweats? Yes No

**Skin –** Have you had:

Recent rashes, lumps, or other skin / hair / nail problems? Yes No \_\_\_\_\_

A history of skin cancer? Yes No

**Eyes –** Have you had:

Recent vision changes? Yes No Last eye appointment: \_\_\_\_\_ With whom? \_\_\_\_\_

Glaucoma/Cataracts? Yes No

**Ears / Nose / Mouth / Throat –** Have you had:

Hearing problems? Yes No

Do you have / use hearing aides? Yes No

Frequent wax impaction? Yes No

Frequent nosebleeds? Yes No

Do you have a history of Obstructive Sleep Apnea? Yes No If yes, do you use a CPAP? Yes No

Do you snore? Yes No

Do you have excessive daytime fatigue? Yes No

Do you notice SIGNIFICANT dizziness, vertigo? Yes No

**Cardiovascular -** Do you get:

Chest pain / pressure / tightness / squeezing / discomfort? Yes No

If yes, does it occur with activity or exertion? Yes No

Heart fluttering / flip-flops / skipping or palpitations? Yes No

Swelling of ankles? Yes No

Pain in legs while walking? Yes No

Shortness of breath? Yes No

Do you take antibiotics before dental work? Yes No

Do you exercise on a regular basis? Yes No How often? \_\_\_\_\_ What type? \_\_\_\_\_

**Respiratory** – Have you ever been told that you have:

- Asthma? Yes No  
Emphysema / chronic bronchitis? Yes No  
Blood clots in your leg or lung? Yes No  
Tuberculosis (TB) or positive skin test? Yes No  
Do you notice frequent:  
Wheezing / Shortness of breath? Yes No  
Coughing / Phlegm production? Yes No  
Coughing up blood? Yes No

**Gastrointestinal** – Do you notice:

- Frequent nausea or vomiting? Yes No  
Frequent Diarrhea? Yes No  
Significant constipation? Yes No  
Bloody or black bowel movements? Yes No  
Frequent heartburn / indigestion? Yes No  
Do you take antacids? Yes No If yes, how often? \_\_\_\_\_  
Trouble swallowing? Yes No  
Abdominal Pain? Yes No  
Have you ever been diagnosed with: Ulcers Hepatitis Colitis  
Have you ever had a colonoscopy? Yes No If yes, when? \_\_\_\_\_

**Genitourinary** – Do you notice:

- Burning / frequency or hesitation with urination? Yes No  
Do you wake up in the night to urinate? Yes No  
Do you have difficulty starting your urine stream? Yes No  
Do you have problems holding your urine? Yes No  
Do you have to wear a pad for incontinence? Yes No  
Have you ever had kidney stones? Yes No If yes, last episode? \_\_\_\_\_  
Are you sexually active? Yes No  
Problems with your sex drive? Yes No  
Abnormal discharge? Yes No  
Have you ever had a sexually transmitted disease? Yes No If yes, what type? \_\_\_\_\_  
What kind of birth control do you use? \_\_\_\_\_  
Do you use condoms? Always Most of the time Rarely Never  
Ever engaged in any activity to put you at risk for aids? Yes No If yes, explain \_\_\_\_\_  
Do you want an AIDS test? Yes No  
Have you ever been physically or sexually abused? Yes No  
If yes, would you like to discuss this further? Yes No  
Do you feel safe in your current home/environment? Yes No

**Women** – Do you have or have you had:

Problems related to menopause? Yes No  
Prolonged or abnormal bleeding? Yes No  
Pelvic pain? Yes No  
An abnormal pap smear? Yes No If yes, when? \_\_\_\_\_  
An abnormal mammogram? Yes No If yes, when? \_\_\_\_\_  
Breast discharge, masses or cancer? Yes No  
When was your last: Pap Smear \_\_\_\_\_ Mammogram \_\_\_\_\_  
Do you perform self breast exams regularly? Yes No  
Number of pregnancies? \_\_\_\_\_ Births? \_\_\_\_\_ Miscarriages? \_\_\_\_\_

**Men:**

Do you have difficulty with erections? Yes No  
Would you like to discuss this further? Yes No

**Musculoskeletal** – Do you have or have you had:

Significant joint pain or arthritis? Yes No  
Gout? Yes No  
Neck pain? Yes No  
Back pain? Yes No  
Have you had a Bone Density Study? Yes No If yes, when? \_\_\_\_\_

**Neurological** – Do you have or have you had:

Tremors / shakes? Yes No  
Memory problems? Yes No  
Seizures? Yes No If yes, how often? \_\_\_\_\_  
A significant fall in the past year? Yes No  
Headaches? Yes No If yes, how often? \_\_\_\_\_  
Blackouts / fainting spells? Yes No  
Numbness / tingling? Yes No If yes, where is it located? \_\_\_\_\_

**Mental / Emotional**

In the past 2 weeks, have you felt down, depressed, or hopeless? Yes No  
Have you recently had little interest or pleasure in daily activities? Yes No  
Have you ever had depression so severe that you considered suicide? Yes No  
Do you feel that you worry excessively? Yes No  
Have you seen a psychiatrist/therapist in the past? Yes No If yes, when? \_\_\_\_\_ By whom? \_\_\_\_\_

**Hematologic / Lymphatic & Allergic / Immunologic** – Have you had:

Anemia? Yes No  
Problems with your spleen? Yes No  
Bleeding or clotting problems? Yes No  
Easy bruising? Yes No  
Seasonal allergies/hay fever? Yes No If yes, what do you take? \_\_\_\_\_  
Food, latex or **drug allergies**? Yes No If yes, from what food and/or drug with what type of reaction? \_\_\_\_\_  
Have you ever seen an allergist? Yes No If yes, when? \_\_\_\_\_ By whom? \_\_\_\_\_

Do you have any other questions or concerns today? \_\_\_\_\_