Loudoun Valley Family Practice
205 E. Hirst Road ■ Suite 200 ■ Purcellville, VA 20132 ■ Ph: 540-338-6101 ■ Fax: 540-338-7803

# HEALTH HISTORY FORM

**Name:** _____ **Date of Birth:** _____

What is the reason for your visit today?

**PAST MEDICAL HISTORY** (Conditions that you currently have and are being treated for, conditions that you have been treated for in the past. Examples: High blood pressure, diabetes, anxiety, depression, sleep apnea, cancer, etc.)

| | | |
|---|---|---|
| | | |
| | | |
| | | |

**PAST SURGICAL HISTORY** (Examples: Tonsillectomy, sinus surgery, appendectomy, heart stent, etc.)

| | | |
|---|---|---|
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| | | |
| | | |

**CURRENT MEDICATIONS** (Attach a list of medications if preferred. If none, please write none. If you need more room, please use the back of the paper)

| Name: | Dosage: | Reason: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## ALLERGIES

Are you allergic to any Medication(s)? ☐ Yes ☐ No If yes, please list the Medication & Reaction below:

Do you have environmental allergies? ☐ Yes ☐ No If yes, please list below:

## SOCIAL HISTORY

| Do you smoke cigarettes? | Do you drink alcohol? | Do you use recreational drugs? |
|---|---|---|
| ☐ Yes ☐ No<br>☐ Less than 1 pack/day<br>☐ 1-2 packs/day<br>Do you have any plans to quit? | ☐ Yes ☐ No<br>If yes, how much do you drink a week?<br>Do you plan to quit? | ☐ Yes ☐ No<br>If yes, what kind of drugs do you use, and how often? |

**Marital Status** (Check One): ☐ Married ☐ Single ☐ Divorced

How many children (if any): _____

| **FAMILY MEDICAL HISTORY:** (Please check any medical problems that any family member has or had) | | | | | | | |
|---|---|---|---|---|---|---|---|
| Relative | Diabetes | Alcoholism | Drug Abuse | High Cholesterol | Suicide | Depression | Cancer (Type) |
| Father | | | | | | | |
| Mother | | | | | | | |
| Sibling | | | | | | | |
| M. Grandmother | | | | | | | |
| M. Grandfather | | | | | | | |
| P. Grandmother | | | | | | | |
| P. Grandfather | | | | | | | |
| Other | | | | | | | |

| **IMMUNIZATIONS HISTORY** | | |
|---|---|---|
| Have you had this vaccine? | | Date of Last Shot |
| TDAP | ☐ Yes ☐ No | |
| Hepatitis B | ☐ Yes ☐ No | |
| Influenza | ☐ Yes ☐ No | |
| Pneumococcal 23 | ☐ Yes ☐ No | |
| Prevnar | ☐ Yes ☐ No | |
| Shingles Zoster Vaccine | ☐ Yes ☐ No | 1st Dose: |
| | | 2nd Dose: |

| **PREVENTION** | |
|---|---|
| Date of last Colonoscopy: | |
| **Females Only:** | |
| Date of last Pap examination: | |
| Date of last Mammogram: | |
| Last menstrual cycle: | |
| Are you on Birth Control? | ☐ Yes ☐ No |

## Review of Systems

| General | |
|---|---|
| Weight Changes | □ Yes □ No |
| Fatigue | □ Yes □ No |
| Fever/Chills | □ Yes □ No |
| Weakness | □ Yes □ No |
| **Head and Neck** | |
| Earache | □ Yes □ No |
| Hearing Loss | □ Yes □ No |
| Ear Drainage | □ Yes □ No |
| Ringing in Ears | □ Yes □ No |
| | |
| Nasal Drainage | □ Yes □ No |
| Nose Bleeds | □ Yes □ No |
| Sinus Congestion | □ Yes □ No |
| Sore Throat | □ Yes □ No |
| **Gastrointestinal** | |
| Difficulty Swallowing | □ Yes □ No |
| Indigestion | □ Yes □ No |
| Diarrhea | □ Yes □ No |
| Heartburn | □ Yes □ No |
| Abdominal Pain | □ Yes □ No |
| Nausea | □ Yes □ No |
| Constipation | □ Yes □ No |
| Rectal Bleeding | □ Yes □ No |
| **Cardiovascular** | |
| Chest Pain | □ Yes □ No |
| Shortness of Breath | □ Yes □ No |
| Palpitations | □ Yes □ No |
| Shortness of Breath Upon Waking | □ Yes □ No |
| **Vascular** | |
| Calf Pain | □ Yes □ No |
| Leg Cramping | □ Yes □ No |

| Neurological | |
|---|---|
| Dizziness | □ Yes □ No |
| Fainting | □ Yes □ No |
| Headaches | □ Yes □ No |
| Seizures | □ Yes □ No |
| Weakness | □ Yes □ No |
| Numbness | □ Yes □ No |
| Tremor | □ Yes □ No |
| Lightheaded | □ Yes □ No |
| **Respiratory** | |
| Wheezing | □ Yes □ No |
| Cough | □ Yes □ No |
| Sputum | □ Yes □ No |
| Pain with Breathing | □ Yes □ No |
| **Skin** | |
| Rash | □ Yes □ No |
| Itching | □ Yes □ No |
| Color Changes | □ Yes □ No |
| Hair/Nail Changes | □ Yes □ No |
| Lumps | □ Yes □ No |
| **Hematology** | |
| Easy Bleed | □ Yes □ No |
| Easy Bruising | □ Yes □ No |
| **Eyes** | |
| Eye Pain | □ Yes □ No |
| Eye Redness | □ Yes □ No |
| Vision Loss | □ Yes □ No |

| Endocrine | |
|---|---|
| Heat/Cold Intolerance | □ Yes □ No |
| Sweating | □ Yes □ No |
| Change in Appetite | □ Yes □ No |
| Excessive Thirst | □ Yes □ No |
| **Musculoskeletal** | |
| Joint Pain | □ Yes □ No |
| Stiffness | □ Yes □ No |
| Joint Swelling | □ Yes □ No |
| Muscle Cramps | □ Yes □ No |
| **Immunological** | |
| Food Allergy | □ Yes □ No |
| Seasonal Allergy | □ Yes □ No |
| **Genitourinary** | |
| Frequency | □ Yes □ No |
| Urgency | □ Yes □ No |
| Pain When Urinating | □ Yes □ No |
| Excessive Nighttime Urination | □ Yes □ No |
| Blood in Urine | □ Yes □ No |
| Incontinence | □ Yes □ No |
| Menstrual Problem | □ Yes □ No |
| **Psychological** | |
| Anxiety | □ Yes □ No |
| Depression | □ Yes □ No |
| Memory Loss | □ Yes □ No |
| Stress | □ Yes □ No |
| Nervousness | □ Yes □ No |
| **Neck** | |
| Stiffness | □ Yes □ No |
| Pain | □ Yes □ No |
| Lumps | □ Yes □ No |
| Swollen Glands | □ Yes □ No |