LOUDOUN INTERNAL MEDICINE ASSOCIATES

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Office Phone # 703-858-3220

Patient's Full Name: _____

Date of Birth: _____

Birth Sex: □ Male □ Female Preferred Pronouns: _____

Gender Identity: □ Male □ Female ☐ Female-To-Male/Transgender Male ☐ Male-To-Female/Transgender Female

□ Non-Binary □ Choose not to disclose □ Other, please specify: _____

Sexual Orientation: □ Heterosexual □ Homosexual ☐ Bisexual ☐ Pansexual ☐ Asexual

☐ I'm not sure ☐ Other _____ ☐ Choose not to disclose

Past Medical History: (Please check all that apply)

□ Anemia	□ Heart Attack
□ Anxiety	□ High Blood Pressure
□ Attention Deficit Disorder (ADD)	□ Blood disorders
□ Atrial Fibrillation	□ Insomnia
□ Asthma	□ Leukemia
□ Alcohol use disorder	□ Lupus
□ Back problems	□ Lyme disease
□ Breast Cancer	□ Rheumatoid Arthritis
□ Cardiomyopathy	□ Migraines/Chronic headaches
□ Chronic Kidney Disease	□ Obstructive Sleep Apnea
□ Colon Cancer	□ Organ Transplant; If yes, specify:
□ Concussion	□ Osteoporosis
□ Depression	□ Osteoarthritis
□ Diabetes Mellitus – Type 1	□ Pneumonia
□ Diabetes Mellitus – Type 2	□ Pregnancy; If yes, how many total?_____
□ Dementia	□ Prostate Cancer
□ Eczema	□ Other connective tissue disorders (Sjogrens, Scleroderma)
□ Emphysema	□ Seizure disorder
□ Glaucoma	□ Substance abuse disorder
□ Gastroesophageal Reflux Disease (GERD)	□ Skin cancer
□ Lung cancer	□ Stroke
□ Herpes (HSV-1 or HSV-2)	□ Thyroid disorder
□ HIV infection	□ Chronic Obstructive Pulmonary Disease
□ Heart Disease	□ Kidney Stones
□ Uterine Cancer	□ Cervical Cancer

Surgical History – Please include any surgeries and the approximate date/year

_____

_____

_____

_____

_____

Additional Screenings

- Have you had a Colonoscopy? _____ If yes, when? _____
- Have you had a Mammogram? _____ If yes, when? _____
- Have you had a Pap smear? _____If yes, when? _____
- Have you had a Bone Density Scan/DEXA? _____ If yes, when? _____

Family History: (Please check all that apply)

	Father	Mother	Brother	Sister	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother
Deceased – Yes or No?								
Alcohol use disorder	□	□	□	□	□	□	□	□
Asthma	□	□	□	□	□	□	□	□
Bleeding disorder	□	□	□	□	□	□	□	□
Blood cancers	□	□	□	□	□	□	□	□
Depression/Anxiety	□	□	□	□	□	□	□	□
Diabetes	□	□	□	□	□	□	□	□
Substance Abuse	□	□	□	□	□	□	□	□
Seizure disorder	□	□	□	□	□	□	□	□
Heart Disease	□	□	□	□	□	□	□	□
High Blood Pressure	□	□	□	□	□	□	□	□
High Cholesterol	□	□	□	□	□	□	□	□
Dementia	□	□	□	□	□	□	□	□
Stroke	□	□	□	□	□	□	□	□
Suicide	□	□	□	□	□	□	□	□
Thyroid Problems	□	□	□	□	□	□	□	□
Kidney disease	□	□	□	□	□	□	□	□
Breast cancer	□	□	□	□	□	□	□	□
Colon cancer	□	□	□	□	□	□	□	□
Lung cancer	□	□	□	□	□	□	□	□
Prostate cancer	□	□	□	□	□	□	□	□
Obesity	□	□	□	□	□	□	□	□

Please list any other family medical history: _____

_____

_____

Safety Information:

	Yes	No		Yes	No
Do you use seat belts?	□	□	Do you have a living will?	□	□
Do you wear a helmet when cycling/skiing/snowboarding/riding horses/operating motorcycles?	□	□	Do you have an advanced directive?	□	□
Do you have smoke detectors in your home?	□	□	Do you practice a healthy diet?	□	□
Do you use sunscreen?	□	□	Do you have any guns in your home?	□	□

Please list any vaccine history: _____

_____

Social/Lifestyle History:

Relationship Status: □ Single □ Married □ Long-term Relationship □ Widowed □ Divorced □ Separated

If married or in long-term partnership – what is their name? _____

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

What is your occupation: _____

What are your hobbies: _____

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 currently smoke cigarettes, cigars, chewing tobacco, marijuana or use a vaping device? _____?

- If yes, for how many years: _____?
- How many cigarettes, cigars, or the concentration of vape per day _____?

Are you a former smoker: _____?

- If yes, when did you quit: _____
- Cigarettes (#Packs/day): _____ Cigars: _____. Chew Tobacco: _____. Vape: _____

Have you ever used recreational drugs: _____

- If yes, when was the last time: _____
- What kind did you use: _____

Do you drink alcohol? □ Never □ Monthly □ Weekly □ Daily

- If yes, how many drinks per day or occasion? _____

Do you drink caffeine?

- If yes, how much: _____

Have you ever worked with chemicals, paints, asbestos, or any hazardous material?: _____

- If yes, what kind: _____

Current Medications: (Please include all prescribed, over-the-counter, vitamins, herbal medication/supplements)

Medication	**Dose**	**Frequency**

Medication allergies: ☐ Yes ☐ No If yes, specify: _____