9010 Lorton Station Blvd, Suite 250
Lorton, Virginia 22079
571-285-2020

Name_____ Today's Date_____ Date of Birth_____ Sex: ____

Reason for your visit?_____

Primary Physician_____ Referring Physician_____

SYMPTOMS Check (√) symptoms you currently have

General	Gastrointestinal	Heart/Lungs	Other
☐ Anxiety/Nervousness	☐ Poor appetite	☐ Chest pain	☐ Frequent urination
☐ Depression	☐ Abdominal bloating	☐ Irregular heart beat	☐ Blood in urine
☐ Unusual weight loss	☐ Change in bowel habits	☐ Excessive phlegm	☐ Muscle aches
☐ Fatigue	☐ Abdominal pain	☐ Short of breath	☐ Joint aches
☐ Lightheadedness	☐ Diarrhea	☐ Cough	☐ Hearing problems
☐ Heat or cold intolerance	☐ Constipation	☐ Other:	☐ Vision problems
☐ Fever/chills	☐ Difficulty swallowing	**Skin**	☐ Swelling in legs/feet
☐ Headache	☐ Heartburn/regurgitation	☐ Rash	☐ Genital/ GYN problems
☐ Memory difficulty	☐ Indigestion	☐ Bleeding/bruising	☐ Abnl Pap/Mammogram
	☐ Nausea/vomiting	☐ Itching	Other:
	☐ Blood in stool	☐ Jaundice/yellow skin	

PERSONAL MEDICAL HISTORY Check (√) medical conditions you have or had in the past

☐ Acid Reflux/ Heartburn	☐ Colitis	☐ Hepatitis	☐ Osteoporosis
☐ Alcoholism	☐ Depression	☐ High blood pressure	☐ Stroke
☐ Anemia	☐ **Diabetes**	☐ High cholesterol	☐ Substance abuse
☐ Anorexia/bulimia	☐ Diverticulosis	☐ HIV/AIDS	☐ Thyroid disease
☐ Arthritis/gout	☐ Emphysema	☐ Irritable bowel	☐ Tuberculosis
☐ Asthma	☐ Epilepsy/seizures	☐ Kidney disease	☐ Ulcers
☐ Bleeding disorder	☐ Gallstones	☐ Liver disease	☐ Uterine bleeding/fibroid
☐ Blood clots/embolism	☐ Heart disease/attack	☐ Lung disease	
☐ Cancer	☐ Heart arrhythmia	☐ Mental illness	

Other/Specify:

FAMILY HISTORY

Check (√) if any blood relatives have had:	Medical information about your biological family (i.e., ages, medical conditions, types of cancer, etc.):
☐ Glaucoma	Father:
	Mother:
☐ Macular degeneration	Siblings:
☐ Amblyopia/ lazy eye	

MEDICATIONS (name and dose; including over-the-counter)	**ALLERGIES/REACTION**

PREVIOUS SURGERIES, MAJOR INJURIES, OR HOSPITALIZATIONS Please list (including year)	

MEANINGFUL USE INFORMATION

RACE
□ Black or African American
□ Caucasian
□ Asian
□ Hispanic
□ American Indian
□ Other

ETHNICITY
□ Hispanic or Latino
□ Not Hispanic or Latino
□ Decline to State

SMOKING STATUS
□Current every day smoker
□Social Smoker
□Former Smoker
□Never smoked

PREFERRED LANGUAGE
□ English
□ Spanish
□ French
□ Other

_____ _____
Patient Signature Date

_____ _____
Physician Signature Date