# Seven Corners Medical Center

6045 Arlington Blvd, Falls Church, VA 22044 Phone: 703-237-7900 Fax: 703-237-0821

| Name | Date of Birth | Age | Sex |
|---|---|---|---|
| | | | |
| **Social Security Number** | **Home Telephone** | **Office Telephone** | **Mobile** |
| | | | |

## MEDICAL HISTORY

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Hernia | | | Thyroid Trouble: | | | Severe Skin Disorder: | | |
| Jaundice: | | | Difficulty Breathing: | | | Epilepsy/Seizures: | | |
| Diabetes: | | | Asthma/Hay Fever: | | | Frequent Trouble Sleeping: | | |
| Paralysis: | | | Heart Murmur: | | | Excessive Weight Gain/Loss: | | |
| Depression: | | | Chest Pain/Pressure: | | | Shock/Psychiatric Treatment | | |
| Emphysema | | | Heart Attack/Angina: | | | Difficulty Walking/Climbing: | | |
| Tuberculosis | | | High Blood Pressure: | | | Other: | | |
| Hearing Defect: | | | Stomach Ulcers: | | | **FEMALES ONLY** | | |
| Any Tumor/Cancer: | | | Rectal Bleeding: | | | Currently Pregnant: | | |
| Cataract / Glaucoma: | | | Prolonged Diarrhea: | | | Painful Menstruation: | | |
| Dizziness/Fainting Spells: | | | Hemorrthoids: | | | Last normal Menstrual period: | | |
| Frequent/Severe Headache: | | | Kidney Stone/Bloody Urine: | | | Other: | | |
| Any Other Conditions: | | | | | | | | |

Please explain any "Yes" answers:

## FAMILY HISTORY

| FAMILY HISTORY | Age | Significant Medical History | Deceased - Cause of Death |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Brother(s) | | | |
| | | | |
| Sister(s) | | | |
| | | | |

## GENERAL HISTORY

| | Yes | No | | | |
|---|---|---|---|---|---|
| Do you Smoke? | | | If "Yes", How Often? | If past smoker, When did you quit? | |
| Do you drink Alcohol? | | | If "Yes", How much? | How frequently? | |
| Any substance abuse? | | | If "Yes", Which substance? | How frequently? | |

## CURRENT MEDICATIONS

| Name of Medication | Dosage | Duration | Physician's Comments |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## ALLERGIES TO MEDICATION

| Name of Medication | Type of Reaction |
|---|---|
| | |
| | |

## SURGERIES

| SURGERIES | Dates |
|---|---|
| | |
| | |

I hereby certify that the information provided above by me, is complete and true to the best of my knowledge

Signature of Patient/Guardian Date

## Physician's Comments

Signature of Physician Date