**Sally A. McFarland MD, PC 4001 Fair Ridge Dr., Suite 306, Fairfax, VA 22033 703-539-8601**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Thank you for making your appointment with us for a complete physical. Please take a few minutes to complete these forms, and bring them with you to your appointment, so that we may better know your history. Please let us know if you have any questions.*

**Please list any prescription medications you take, including strength, and frequency:**

**Please list any over-the-counter medications you take:**

(Including vitamins, herbal, and alternative medications)

Has any blood relative had: (please check appropriate box)

No Yes

Colon cancer  

Breast cancer  

Ovarian cancer  

Malignant melanoma  

Severe reaction to anesthetic  

Heart attack < age 55  

Glaucoma  

Abdominal aortic aneurysm  

Hip fracture  

Diabetes  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last tetanus vaccination? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you have chicken pox in the past? No  Yes 

Have you ever had a blood transfusion? No  Yes 

Have you ever had a positive (abnormal) TB skin test? No  Yes 

Have you had the BCG (tuberculosis) vaccine? No  Yes 

*(This is not routinely given in the United States)*

Have you ever had a severe reaction to anesthetic? No  Yes 

Have you ever taken diet pills such as Fen-Phen or Redux? No  Yes 

Have you ever had a colonoscopy? No  Yes 

If so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*Do you want to be tested for HIV? No  Yes 

\*\*Do you have questions about HIV testing? No  Yes 

Patient’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sally A. McFarland MD, PC 4001 Fair Ridge Dr., Suite 306, Fairfax, VA 22033 703-539-8601**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate the current age of your blood relatives (of age at death, if deceased) and any medical problems they may have (have had). The list below serves as a reminder of common medical conditions.

Medical Conditions: Age: Living/deceased:

Mother:

Father:

Siblings:

Other relatives with serious illnesses:

Common medical conditions:

Diabetes Gout Abnormal Blood clotting

High blood pressure Alcoholism Bladder problems

Stroke Glaucoma Thyroid disease

Heart attach < age 55 Blindness Tuberculosis

Heart attack > age 55 Deafness Cystic Fibrosis

Cancer Migraines Skin Disease

Depression Asthma Sickle Cell Anemia

Psychiatric illness Allergies Stomach problems/ulcers

Kidney disease Epilepsy Colon polyps/bowel disease

Liver disease Arthritis Genetic/hereditary problems

Do you smoke/use tobacco products now? No Yes Have you in the past? No  Yes 

How many alcohol-based drinks do you usually have:

\_\_\_\_None or \_\_\_\_ per day or \_\_\_\_ per week or \_\_\_\_ per month or \_\_\_\_ per year

Do you use drugs such as marijuana or cocaine? No  Yes  Have you in the past? No  Yes 

Have you ever had problems (health, legal, driving, family, work) due to alcohol or drugs? No  Yes 

Patient’s signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sally A. McFarland MD, PC 4001 Fair Ridge Dr., Suite 306, Fairfax, VA 22033 703-539-8601**

**Please check “yes” to present problems or significant problems in the past.**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GENERAL No Yes HEART/VESSELS No Yes**

1. Persistent fever   1. Chest discomfort  
2. Excessive fatigue   2. Palpitations  
3. Daytime sleepiness   3. Irregular heartbeat  
4. Easy bruising/bleeding   4. Night time leg cramps  
5. Hot flashes/night sweats   5. Leg cramps with exercise  
6. Swollen glands   6. Ankle or leg swelling  
7. Poor appetite   7. Problems with exercise  
8. Trouble sleeping   **STOMACH/BOWEL No Yes**
9. Unusual stress   1. Abdominal pain  
10. Excessive snoring   2. Loss of appetite  
11. Breathing stops while sleeping   3. Nausea/vomiting  
12. Falling asleep at inappropriate times   4. Trouble swallowing  

**EYES/EARS No Yes** 5. Difficulty eating  

1. Wear glasses or contacts   6. Feeling full too quickly  
2. Night blindness   7. Bloating  
3. Blurred vision   8. Heartburn or indigestion  
4. Double vision   9. Change in bowel habits  
5. Crossed eyes (lazy eye)   10. Blood in stool or on tissue  
6. Frequent infections   11. Constipation  
7. Glaucoma   12. Diarrhea  
8. Cataracts   13. Hemorrhoids  
9. Eye pain   14. Jaundice  

Retinal detachment   15. Black or tarry stools  

1. Hearing loss   16. Grey or pale stools  
2. Ringing in ears   **URINARY No Yes**
3. Perforation of eardrum(s)   1. Burning with urination  
4. Ear pain   2. Urgent urination  

**NOSE/THROAT/NECK No**  **Yes** 3. Frequent urination  

1. Allergy symptoms   4. Difficulty urinating  
2. Frequent nosebleeds   5. Dribbling after urination  
3. Loss of smell or taste   6. Difficulty holding urine  
4. Sinus trouble/congestion   7. Blood in urine  
5. Hoarseness   8. Black or brown urine  
6. Sores in mouth   9. Bladder/kidney infection  
7. Bleeding gums   10. Kidney stones  
8. Lumps or swelling   11. Urinating > once per night  

**LUNGS/CHEST No Yes BONE/MUSCLE No Yes**

1. Frequent cough   1. Foot pain/problems  
2. Coughing up blood   2. Back or neck pain  
3. Shortness of breath   3. Muscle pain  
4. Wheezing   4. Joint stiffness/swelling  
5. Waking up short of breath   5. Unstable joint  
6. Abnormal chest X ray   7. Height loss  

Patient’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sally A. McFarland MD, PC 4001 Fair Ridge Dr., Suite 306, Fairfax, VA 22033 703-539-8601**

**Please check “yes” to present problems.**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NERVOUS SYSTEM No Yes Year MEN ONLY: No Yes Year**

1. Recurrent severe headache   \_\_\_\_\_ 1. Prostate enlargement   \_\_\_\_\_
2. Migraine headaches   \_\_\_\_\_ 2. Prostate infections   \_\_\_\_\_
3. Tension headaches   \_\_\_\_\_ 3. Discharge from penis   \_\_\_\_\_
4. Cluster headaches   \_\_\_\_\_ 4. Lump or swelling in testicle   \_\_\_\_\_
5. Sinus headaches   \_\_\_\_\_ 5. Undescended testicle   \_\_\_\_\_
6. Other headaches   \_\_\_\_\_ 6. Difficulty with erections   \_\_\_\_\_
7. Dizziness/lightheadedness   \_\_\_\_\_ 7. Testicular tumor   \_\_\_\_\_
8. Vertigo   \_\_\_\_\_ 8. Weak or slow urine stream   \_\_\_\_\_
9. Fainting spells   \_\_\_\_\_ 9. Sexual problems or concerns   \_\_\_\_\_
10. Loss of consciousness   \_\_\_\_\_ 10. Sexually transmitted disease   \_\_\_\_\_
11. Confusion/memory loss   \_\_\_\_\_ **WOMEN ONLY No Yes Year**
12. Difficulty speaking   \_\_\_\_\_ 1. Lumps in the breast   \_\_\_\_\_
13. Trouble with coordination   \_\_\_\_\_ 2. Pain in the breast   \_\_\_\_\_
14. Trouble with balance   \_\_\_\_\_ 3. Infection in the breast   \_\_\_\_\_
15. Epilepsy/seizures   \_\_\_\_\_ 4. Discharge/bleeding from nipple   \_\_\_\_\_
16. Numbness in hands or feet   \_\_\_\_\_ 5. Bleeding between periods   \_\_\_\_\_
17. Tingling in hands or feet   \_\_\_\_\_ 6. Premenstrual symptoms   \_\_\_\_\_
18. Tremors or shaking   \_\_\_\_\_ 7. Irregular periods   \_\_\_\_\_

**ENDOCRINE/GLANDULAR No Yes Year** 8. Menopause   \_\_\_\_\_

1. Poor appetite   \_\_\_\_\_ 9. Bleeding after menopause   \_\_\_\_\_
2. Abnormal cold sensitivity   \_\_\_\_\_ 10. Hot flashes   \_\_\_\_\_
3. Abnormal heat sensitivity   \_\_\_\_\_ 11. Vaginal discharge   \_\_\_\_\_
4. Weight gain > 5# in 6 months   \_\_\_\_\_ 12. Vaginal itching/irritation   \_\_\_\_\_
5. Weight loss > 5# in 6 months   \_\_\_\_\_ 13. Abnormal pap smear   \_\_\_\_\_
6. Hypoglycemia   \_\_\_\_\_ 14. Abnormal mammogram   \_\_\_\_\_
7. Increased thirst   \_\_\_\_\_ 15. Pelvic infections   \_\_\_\_\_
8. Increased appetite   \_\_\_\_\_ 16. Pain with intercourse   \_\_\_\_\_

**SKIN No Yes** Year 17. Bleeding with intercourse   \_\_\_\_\_

1. Persistent skin problems   \_\_\_\_\_ 18. Sexual problems/concerns   \_\_\_\_\_
2. Frequent rashes   \_\_\_\_\_ 19. Sexually transmitted diseases   \_\_\_\_\_
3. Rashes that are not healing   \_\_\_\_\_ 20. Pelvic pain   \_\_\_\_\_
4. Mole enlarging or new mole   \_\_\_\_\_
5. Mole that bleeds   \_\_\_\_\_ Do you do monthly self-breast exams? No  Yes 
6. Mole that has changed color   \_\_\_\_\_ Date of last pap smear \_\_\_\_\_\_\_\_\_\_\_\_
7. Hives   \_\_\_\_\_ Date of last mammogram \_\_\_\_\_\_\_\_\_\_\_\_
8. Acne   \_\_\_\_\_ Date of last dexa scan (bone density) \_\_\_\_\_\_\_\_\_\_\_\_
9. Malignant melanoma   \_\_\_\_\_ Date of last period \_\_\_\_\_\_\_\_\_\_\_\_

**PSYCHIATRIC No Yes Year** Number of pregnancies \_\_\_\_\_\_\_\_\_\_\_\_

1. Depression   \_\_\_\_\_ Number of births \_\_\_\_\_\_\_\_\_\_\_\_
2. Anxiety/panic attacks   \_\_\_\_\_ Number of ectopic (tubal pregnancies) \_\_\_\_\_\_\_\_\_\_\_\_
3. Significant mood swings   \_\_\_\_\_ Number of miscarriages \_\_\_\_\_\_\_\_\_\_\_\_
4. Bipolar disorder   \_\_\_\_\_ Number of abortions \_\_\_\_\_\_\_\_\_\_\_\_
5. Anorexia or bulimia   \_\_\_\_\_ If sexually active, are you using
6. Change in personality   \_\_\_\_\_ birth control? No  Yes 
7. Other psychiatric concerns   \_\_\_\_\_

Patient’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any medication? No  Yes 

*If you are allergic to a medication, please list the medication and the reaction you had: (This includes prescription and over-the-counter medications, supplements, herbal medications, latex, and radiology products such as iodine contrast or dye, and gadolinium.)*

Medication: Reaction:

Are you allergic to peanuts, eggs, or any food? No  Yes 

*Please list any foods to which you are allergic, and the reaction you had:*

*Please list any other medications/medical products that you cannot take or use for any reason:*

*\*\*If you need more room, please attach another sheet of paper.*

**PAST MEDIAL HISTORY:**

Please list any surgeries you have had, and the year:

**Surgery: Year:**

Please list other hospitalizations:

**Hospitalization: Year:**

Please list all medical conditions: (e.g. seasonal allergies, high cholesterol, high blood pressure, etc.)

Patient’s signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_