

B. Rajesh, M.D.
Internal Medicine

Name _____ Today's Date _____

Date of Birth _____ Birth Place _____

By whom were you referred? _____

What is the reason that you decided to see a physician? _____

PERSONAL HISTORY (PATIENT PROFILE)

1. Marital Status: (Circle one) Married Single Separated Divorced

Previous Marriages: YES NO If yes, number _____ Duration _____

2. Living Situation: (Circle one) Own Home Rent (house, apartment) Other _____

3. Education: Highest level achieved _____

4. Occupation _____: Usual hours per day _____ shift _____

5. Nationality or culture origin (optional) _____ Religion (optional) _____

6. Habits:

Do you wear your seat belt? (Circle one) Always Sometimes Never

Hours of sleep per day _____

Do you smoke? _____ Packs per day _____ How many years? _____

Did you smoke? _____ Packs per day _____ When did you quit? _____

Do you use any other tobacco products? (Chew, Cigar, pipe, Snuff, etc.) _____

Alcohol consumption per week _____

Recreational Drugs? (Marijuana, Cocaine, Speed, LSD, Heroine or other) YES NO

If yes, what? _____ When? _____

Herbal Remedies? _____

7. Hobbies (Circle those that apply) Music Sports Crafts Other _____

8. Exercise and Recreation: (List activity and indicate how often) _____

9. Do you currently see any other physicians? YES NO

If yes, who? _____

(OVER)

FAMILY HISTORY

	Past and Current Health Problems	Age at Death	Cause
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Mother			
Father			
Siblings			
Children			
Grandchildren			

If not noted above, please circle any of the following which have occurred in any of your family members (alive or deceased):
Cancer, high blood pressure, heart attacks, strokes, diabetes, glaucoma, chronic diseases of heart, lung or kidneys, liver, serious mental condition, depression, nervous condition or suicide.

PAST MEDICAL HISTORY

1. Illnesses

Childhood:

Problem	Yes	Problem	Yes
Measles		Scarlet Fever	
Mumps		Rheumatic Fever	
Chicken Pox		Mono	
Polio		TB	
Other (List)			

Adult:

Problem	Yes	Problem	Yes
Severe Head Trauma		Chronic Constipation	
Concussion		Food Intolerance	
Seizures/Convulsions		Milk Intolerance	
Chronic Sinusitis		Kidney/Bladder Infection	
Chronic Ear Infection		Kidney Stones	
Chronic Sore Throats		Eczema or Other Rash	
Pneumonia		Hives	
Asthma/Wheezing		Broken Bones	
Cholesterol		Thyroid	
Heart Murmur		Diabetes	
High Blood Pressure		Ulcers	
Chronic Diarrhea		Cancer	
Depression/Anxiety		Glaucoma/Cataracts	
Heart Attack		Emphysema / Chronic Bronchitis	
Heart Failure		Gout	
Other Heart Problems		Stroke	

2. Hospitalizations other than for surgery

Year	Hospital	Reason	Physician
a.			
b.			
c.			
d.			
e.			

3. Operations

Kind	Year	Hospital	Surgeon	Result
a.				
b.				
c.				
d.				
e.				

4. Medications

Name	Strength (mg)	Schedule	Prescribed By
a.			
b.			
c.			
d.			
e.			
f.			
g.			
h.			

5. What Pharmacy do you use? _____

6. Allergies (to what): _____

Type of reaction (Circle those that apply)

RASH HIVES WHEEZING DIARRHEA UPSET STOMACH VOMITING

7. Immunizations: Full Series Partial None Don't Know

When was your last Tetanus? _____

When was your last pneumo vaccination? _____

8. Have you ever used narcotic medications? _____

CHECK IF EXPERIENCING ANY OF THE BELOW IN THE PAST YEAR:

<input type="checkbox"/> UNEXPECTED WEIGHT LOSS	<input type="checkbox"/> DIFFICULTY SWALLOWING	<input type="checkbox"/> FREQUENCY
<input type="checkbox"/> UNEXPECTED WEIGHT GAIN	<input type="checkbox"/> PAIN WHILE SWALLOWING	<input type="checkbox"/> DYSURIA
<input type="checkbox"/> MORE THIRSTY LATELY	<input type="checkbox"/> THYROID PROBLEM	<input type="checkbox"/> HEMATURIA
<input type="checkbox"/> TIREDNESS/WEAKNESS	<input type="checkbox"/> NECK STIFFNESS	<input type="checkbox"/> NOCTURIA
<input type="checkbox"/> FEVERS/CHILLS	<input type="checkbox"/> NECK PAIN	<input type="checkbox"/> URGENCY
<input type="checkbox"/> NIGHT SWEATS	<input type="checkbox"/> SWOLLEN GLANDS	<input type="checkbox"/> HESITANCY
<input type="checkbox"/> FEELING HOTTER		<input type="checkbox"/> DRIBBLING
<input type="checkbox"/> FEELING COLDER	<input type="checkbox"/> COUGH	<input type="checkbox"/> INCONTINENCE
<input type="checkbox"/> HOT FLASHES	<input type="checkbox"/> PHLEGM	<input type="checkbox"/> KIDNEY STONES
<input type="checkbox"/> SNORING	<input type="checkbox"/> HEMOPTYSIS	
<input type="checkbox"/> APNEA/QUITTING BREATHING	<input type="checkbox"/> WHEEZING	<input type="checkbox"/> LEG SWELLING
	<input type="checkbox"/> SHORTNESS OF BREATH	<input type="checkbox"/> LEG CRAMPS
	<input type="checkbox"/> ABNORMAL CHEST XRAY	<input type="checkbox"/> RESTLESS LEGS
	<input type="checkbox"/> POSITIVE TB TEST	<input type="checkbox"/> LEG PAINS AFTER WALK
<input type="checkbox"/> BLURRED VISION		<input type="checkbox"/> VARICOSE VEINS
<input type="checkbox"/> DOUBLE VISION	<input type="checkbox"/> CHEST PAIN	<input type="checkbox"/> BLOOD CLOTS IN PAST
<input type="checkbox"/> EYE PAIN OR ITCH	<input type="checkbox"/> PALPITATION	
<input type="checkbox"/> REDNESS	<input type="checkbox"/> RACING HEART/PALPITATION	<input type="checkbox"/> MUSCLE PAINS
<input type="checkbox"/> CATARACTS	<input type="checkbox"/> IRREGULAR HEART BEATS	<input type="checkbox"/> JOINT PAINS-WHICH ONES-
<input type="checkbox"/> FLASHING LIGHTS	<input type="checkbox"/> SWELLING OF LEGS	
<input type="checkbox"/> EXCESSIVE TEARING	<input type="checkbox"/> NEED TWO PILLOWS TO SLEEP	<input type="checkbox"/> JOINT STIFFNESS
<input type="checkbox"/> GLASSES	<input type="checkbox"/> FEET/HANDS COLD/BLUE	<input type="checkbox"/> BACKACHE
<input type="checkbox"/> LAST EYE CHECK WAS IN	<input type="checkbox"/> PACEMAKER	<input type="checkbox"/> SHOOTING PAINS IN LEGS
<input type="checkbox"/> TEMPORARY BLINDNESS	<input type="checkbox"/> MURMUR	<input type="checkbox"/> NECK PAIN
<input type="checkbox"/> COLORED HALO	<input type="checkbox"/> NEED FOR ANTIBIOTICS	
	<input type="checkbox"/> BEFORE DENTAL VISIT	<input type="checkbox"/> HIGH CHOLESTEROL
<input type="checkbox"/> HEARING PROBLEMS		<input type="checkbox"/> HIGH TRIGLYCERIDES
<input type="checkbox"/> HEARING AIDS	<input type="checkbox"/> HEARTBURN	<input type="checkbox"/> DIABETES MELLITUS
<input type="checkbox"/> VERTIGO	<input type="checkbox"/> STOMACH PAINS	<input type="checkbox"/> POTASSIUM PROBLEMS
<input type="checkbox"/> RINGING IN EARS	<input type="checkbox"/> BLOATING	
<input type="checkbox"/> EAR PAIN	<input type="checkbox"/> NAUSEA	<input type="checkbox"/> HALLUCINATIONS
	<input type="checkbox"/> VOMITING	<input type="checkbox"/> DEPRESSION
<input type="checkbox"/> RUNNY NOSE	<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> ANXIETY
<input type="checkbox"/> STUFFINESS	<input type="checkbox"/> CONSTIPATION	<input type="checkbox"/> PANIC ATTACKS
<input type="checkbox"/> BLEEDING FROM NOSE	<input type="checkbox"/> BLACK STOOLS	<input type="checkbox"/> MEMORY PROBLEMS
<input type="checkbox"/> SINUS TROUBLE	<input type="checkbox"/> BLOOD IN BM	<input type="checkbox"/> MOOD SWINGS
	<input type="checkbox"/> HEPATITIS	<input type="checkbox"/> CRY OFTEN
<input type="checkbox"/> FREQUENT SORE THROAT	<input type="checkbox"/> PANCREATITIS	<input type="checkbox"/> LONELY
<input type="checkbox"/> BLEEDING GUMS	<input type="checkbox"/> JAUNDICE	<input type="checkbox"/> LOSS OF APPETITE
<input type="checkbox"/> SWELLING OF GUMS	<input type="checkbox"/> PAIN IN ANUS	<input type="checkbox"/> WORRY A LOT
<input type="checkbox"/> HOARSENESS		<input type="checkbox"/> TREATMENT- ABOVE IN PAST
<input type="checkbox"/> VOICE CHANGE	<input type="checkbox"/> SKIN RASH	
<input type="checkbox"/> DENTURES	<input type="checkbox"/> ITCHING	<input type="checkbox"/> SEVERE HEADACHES
<input type="checkbox"/> SORES IN MOUTH	<input type="checkbox"/> MOLE CHANGE	<input type="checkbox"/> FAINTING
<input type="checkbox"/> BAD BREATH	<input type="checkbox"/> MOLE REMOVAL	<input type="checkbox"/> DIZZINESS/LIGHTHEADEDNESS
	<input type="checkbox"/> SKIN CANCER	<input type="checkbox"/> STROKE/PARALYSIS
<input type="checkbox"/> ANEMIA	<input type="checkbox"/> SKIN LUMPS	<input type="checkbox"/> MINI STROKE/TIA
<input type="checkbox"/> TRANSFUSION	<input type="checkbox"/> EASY BRUISING	<input type="checkbox"/> TINGLING
<input type="checkbox"/> TRANSFUSION REACTIONS	<input type="checkbox"/> HIVES	<input type="checkbox"/> NUMBNESS
		<input type="checkbox"/> TREMORS
<input type="checkbox"/> FOR WOMEN	<input type="checkbox"/> LAST PERIOD	<input type="checkbox"/> SPEECH PROBLEMS
<input type="checkbox"/> BREAST LUMPS	<input type="checkbox"/> NUMBER OF PREGNANCIES	<input type="checkbox"/> HEAD INJURY
<input type="checkbox"/> BREAST PAIN	<input type="checkbox"/> ARE YOU PREGNANT NOW	
<input type="checkbox"/> BREAST DISCHARGE	<input type="checkbox"/> TYPE OF CONTRACEPTION	
<input type="checkbox"/> BREAST BIOPSIES	<input type="checkbox"/> IF MENOPAUSE WHEN? _____	
<input type="checkbox"/> ABNORMAL MAMMOGRAMS	<input type="checkbox"/> HYSTERECTOMY? _____	
<input type="checkbox"/> BLEEDING FROM NIPPLE	<input type="checkbox"/> DO YOU DO BREAST SELF	
<input type="checkbox"/> IRREGULAR PERIODS	<input type="checkbox"/> EXAMS? _____	
<input type="checkbox"/> SPOTTING	<input type="checkbox"/> LOSS OF SEX DRIVE	
<input type="checkbox"/> HEAVY BLEEDING	<input type="checkbox"/> HOT FLASHES	
<input type="checkbox"/> SEVERE CRAMPS	<input type="checkbox"/> VAGINAL DRYNESS	
<input type="checkbox"/> VAGINAL DISCHARGE		
<input type="checkbox"/> USE OF HORMONES		

I CERTIFY THAT MY ANSWERS TO THESE QUESTIONS ARE ACCURATE AND WILL NOT HOLD THE DOCTOR OR MEDICAL STAFF RESPONSIBLE FOR OMISSIONS.

X _____
PATIENT SIGNATURE

DATE