Thakkar, Patel, Avalos MD's LLC

Date:_____ Name:_____ Date of Birth:_____

Referring Physician:_____

Reason for Visit:_____

Medical History: Please check yes for any conditions that represent a SIGNIFICANT problem for you in the last 12 months.

General	Yes	Gastrointestinal	Yes	Musculoskeletal	Yes
Fever or chills		Abdominal Pain		Joint replacement surgery	
Night Sweats		Nausea		Gout	
Recent weight changes		Vomiting		Arthritis	
Difficulty Sleeping		Heartburn/Indigestion		Bone/ Joint pain	
Eyes		Gallbladder problems		Endocrine	
Glaucoma		Trouble swallowing/choking		Heat or cold intolerance	
Other eye problems		Loss of appetite		Hot flashes	
Ears, Nose, Mouth		Diarrhea'		Excessive thirst	
Nose bleeds		Constipation		Flushing	
Sinus pain/Problems		Rectal pain/itching		Skin	
Earache		Hemorrhoids		Jaundice	
Dentures		Blood in Stool		Easy bruising	
Hearing Loss		Tarry Stools		Psoriasis or Eczema	
Respiratory		Genitourinary		Neurologic	
Cough		Painful urination		Numbness	
Wheezing		Kidney stones		Headaches	
Shortness of Breath		Frequency at night		Stroke	
Asthma		Urgency		TIA	
Cardiovascular		Slow or small stream		Dizziness	
Chest Pain		Blood in urine		Paralysis	
Heart Palpitations		Leaking of urine		Psychiatric	
Irregular heart beat		Poor bladder emptying		Depression	
Heart attack or failure		Menstrual problems		Anxiety	
Heart murmur		Recurrent bladder infections		Other	
Heart Valve problems		Abnormal vaginal bleeding			
Blood clots		Sexual problems			
Feet or Ankle swelling		Prostate problems			

Please list all of your prescription medications. Include Medication name, dosage, and number of times per day.

_____

_____

_____

Please list all of your over the counter medications and vitamin supplements.

_____

_____

Please list all of your allergies including medications, food and environmental.

_____

_____

Past Medical History: Please check if you or your family have ever had any of the following problems.

Problem	You	Family	Problem	You	Family
Ulcerative Colitis			Kidney Disease		
Crohn's Disease			Bleeding Disorder		
Colon Polyps			Blood Transfusion		
Colon Cancer			Tuberculosis		
Ulcer			High Blood Pressure		
Liver Disease			High Cholesterol		
Pancreatic Disease			Diabetes		
Lung Disease			Seizures		
Heart Disease			Psychiatric Disorder		
Thyroid Disease			Depression		

Please list **hospitalizations and surgeries** with approximate dates.

	Date	Hospitalizaton
1		
2		
3		
4		
5		
6		

Family History:

Relative	Living	Current Age	Deceased	Age at Death	Diseases or Cause of Death
Father					
Mother					
Siblings					

Social History:

Marital Status: Married Single Divorced Widowed Other

Do you smoke?: ☐ No ☐ Yes If yes, how many packs per day? _____

Did you smoke?: ☐ No ☐ Yes If yes, how many packs per day? _____

Do you drink alcohol? ☐ No ☐ Yes If yes, indicate on average how much.

Beer _____ per Day Week Month Wine (glasses)_____ per Day Week Month

Mixed Drinks _____ per Day Week Month Other _____ per Day Week Month

Soda products (Colas) _____ per Day Week Month Coffee _____ per Day Week Month

Milk _____ per Day Week Month Ice Cream (Cups) _____ per Day Week Month

Do you have tattoos? No ☐ Yes ☐ Do you or have you ever used street drugs? No ☐ Yes ☐

Do you have any other problems you want to discuss? ☐ No ☐ Yes: _____

Patient Signature: _____ Date:_____