Arlington Gastroenterology Services

Arlington | Southlake

Hamid Kamran, MD FACG

PATIENT MEDICAL INFORMATION

NAME: _____ **DATE:** _____

WEIGHT (LBS): _____ **HEIGHT**: _____**feet** _____**inches**

Do you have, or have you ever experienced the following? ***Check (Y) Yes or (N) No***

Y	N		Y	N		Y	N	
		Abnormal Bleeding			Diabetes			Jaundice (Yellow)
		Alcohol Abuse			Difficulty Breathing			Kidney Problems
		Artificial Valves			Drug Abuse			Liver Disease
		Artificial Bones/ Joints			Emphysema			Mitral Valve Prolapse
		Arthritis			Epilepsy			Pacemaker/ Defibrillator
		Asthma			Fainting Spells			Radiation Treatment
		Blood Pressure (High)			Glaucoma			Rheumatic Fever
		Blood Pressure (Low)			Headaches			Scarlet Fever
		Blood Transfusion			Heart Attack			Seizures
		Cancer			Heart Murmur			Sinus Problems
		Chemotherapy			Heart Surgery			Stroke
		Chest Pain after Exercise			Hepatitis			Thyroid Problems
		Colitis			HIV/ AIDS			Tuberculosis (TB)
		Congenital Heart Disease			Hospitalized			Ulcers/Stomach Disease

Please list any serious medical condition(s) you have experienced:

Please list name of medications you are currently taking:

Please list any drug allergies:

Are you taking any of the following? ***Check (Y) Yes or (N) No***

Y	N		Y	N		Y	N	
		Acetaminophen			Blood Pressure Meds			Nitroglycerin
		Antibiotics			Blood Thinners			Recreational Drugs
		Antidepressant			Cold Remedies			Steroids/ Cortisone
		Antihistamines			Digital/ Heart Medication			Thyroid Medicine
		Aspirin			Insulin/ Diabetes Medication			Tranquilizers

What problems or symptoms did you come to see the doctor about today?

Have you tested positive for COVID 19 in the last 30 days? Circle (Y) ***Yes*** **or (N)** ***No***

Have you traveled outside of the state in the last 30 days? Circle (Y) ***Yes*** **or (N)** ***No***