West Plano Medical Associates

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Patient's Report of Medical History

Patient's Name:	___Male ___Female	**Today's Date:** ___/___/___
Address:		**Date of Birth:** ___/___/___ **Home Phone #:** (____) _____-_____
Employer's Name:	**Job Title:**	**Work Phone #:** (____) _____-_____
Address:		**Cell Phone #:** (____) _____-_____
		Marital Status: __ Single, __ Married, __ Widowed, __ Divorced, __ Separated

Family's History of Disease

Epilepsy? ___Yes ___No	Asthma? ___Yes __No	Hypertension? ___Yes ___No	**Relationship to You:**
Migraine? ___Yes ___No	Anemia? __Yes __No	Lipid Disorder? ___Yes ___No	_____
Mental Illness? ___Yes ___No	Bleed Easily? __Yes __No	Alcoholism? ___Yes ___No	_____
Glaucoma? ___Yes ___No	Osteoporosis? __Yes __No	Hepatitis? ___Yes ___No	_____
Diabetes? ___Yes ___No	Arthritis? __Yes __No	Other?	_____
Thyroid Disease? ___Yes ___No	Heart Disease? ___Yes ___No		
Hay Fever? ___Yes ___No	Stroke? ___Yes ___No		

Hospital Admissions

Reason		Reason	
	Date: ___/___/___		Date: ___/___/___
	Date: ___/___/___		Date: ___/___/___
	Date: ___/___/___		Date: ___/___/___

Questions about How You Are Feeling

Do you have:

Unexplained Weight Loss? ___Yes ___No
Persistent Coughing (for more than 2 weeks)? ___Yes ___No
Night Sweats, Fever, or Chills? ___Yes ___No
Is a family member or close contact receiving treatment f or tuberculosis? ___Yes ___No

Are you feeling ill today? ___Yes ___No
Why did you come to see Dr. Harandi today?

_____

_____

▼ Allergies List ▼		▼ Medications You are Currently Taking ▼	

YOUR MEDICAL HISTORY

Back Pain? __Yes __No
Painful to Urinate? __Yes __No
Frequently Urinating? __Yes __No
Over-active Bladder? __Yes __No
Urinating More Than Once During the Night? __Yes __No
Leaking Urine? __Yes __No
- With Stress, Exercise, or Movement?
(↑ Please circle, if applicable. ↑)
Decrease in Urine Flow or Force? __Yes __No
Blood in Urine? __Yes __No
Urinary Tract Infection? __Yes __No
- Recurrent? __Yes __No
Kidney Stones? __Yes __No
Prostate Problem? __Yes __No
- Type? _____
Allergies? __Yes __No
Types? _____
Gallbladder Problem? __Yes __No
Liver Disease? __Yes __No
- Type? _____
Hemorrhoids? __Yes __No
Hernia? __Yes __No
Weight Loss? __Yes __No
Weight Gain? __Yes __No
Fatigue Easily? __Yes __No
Bruise Easily? __Yes __No
Cancer Diagnosis? __Yes __No
Type/s? _____
Diabetes? __Yes __No
Thyroid Disease? __Yes __No
Arthritis or Rheumatism? __Yes __No
- Where? _____
Bone Fracture? __Yes __No
-Where? _____
Joint Injury? __Yes __No
- Where? _____
Osteoporosis? __Yes __No
Gout? __Yes __No
Rash? __Yes __No
Hives? __Yes __No
Psoriasis? __Yes __No
Eczema? __Yes __No
Trouble Concentrating? __Yes __No
Trouble Sleeping? __Yes __No
Depression? __Yes __No
Nervousness? __Yes __No
Moodiness? __Yes __No
Suicidal Thoughts? __Yes __No
Memory Loss? __Yes __No
Mental Illness? __Yes __No
Rheumatic Fever? __Yes __No
Rubella (German Measles)? __Yes __No
Headache?
- Severe? __Yes __No
- Recurrent? __Yes __No
Sinus Trouble? __Yes __No
Nose Bleed? __Yes __No
- Recurrent? __Yes __No
Sore Throat? __Yes __No
- Frequent? __Yes __No

Hoarseness? __Yes __No
- Prolonged? __Yes __No
Difficulty Swallowing __Yes __No
Hearing Problem? __Yes __No
Ringing in Ear? __Yes __No
Dizzy Spells? __Yes __No
Fainting? __Yes __No
Eye Pain __Yes __No
Vision Problems? __Yes __No
High Blood Pressure? __Yes __No
Seizure? __Yes __No
Stroke? __Yes __No
Tremors (shaking)? __Yes __No
Numbness or Tingling Sensations? __Yes __No
- Where? _____
Heartburn? __Yes __No
Peptic Ulcer? __Yes __No
Nausea? __Yes __No
Vomiting? __Yes __No
Abdominal Pain? __Yes __No
Diarrhea? __Yes __No
Constipation? __Yes __No
Crohn's or Colitis? __Yes __No
Bloody or Tar-like Stool? __Yes __No
Chest Pain? __Yes __No
Irregular Pulse? __Yes __No
Palpitations? __Yes __No
Heart Murmur? __Yes __No
Heart Attack? __Yes __No
Tuberculosis? __Yes __No
Pneumonia or Pleurisy __Yes __No
Bronchitis/Chronic Cough? __Yes __No
Asthma? __Yes __No
Wheezing? __Yes __No
Shortness of Breath? __Yes __No
- From Exertion? __Yes __No
- While Lying Flat? __Yes __No
Loss of Appetite? __Yes __No
Anemia? __Yes __No
Hepatitis? __Yes __No
Leg Pain? __Yes __No
Varicose Veins? __Yes __No
Cold or Numb Feet or Hands? __Yes __No
Herpes? __Yes __No
- Where? _____
AIDS or HIV? __Yes __No
Other Sexually Transmitted Disease? __Yes __No
- Type/s? _____
Sexual Problems? __Yes __No
Decreased Enjoyment of Life? __Yes __No
Decreased Enjoyment of Work? __Yes __No
Alcohol Consumption:
- How many ounces per day? _____
- How many days per week? _____
Caffeine Consumption:
- How many cups of coffee per day? _____
- How many cups of tea per day? _____
- How many caffeinated soft drinks per day? _____
- With Sugar? __Yes __No
- With Artificial Sweetener? __Yes __No
Nicotine Consumption:
- Cigarettes? __Yes __No
- Cigars? __Yes __No
- Pipe? __Yes __No
Do you take unprescribed or illicit drugs? __Yes __No
- Type/s_____
_____
Do you exercise? __Yes __No
- Lightly? ___, Moderately? ___, or Heavily? ____
- How often? _____

FOR LADIES ONLY

Pregnancy:
- Number of Pregnancies? _____
- Number of Live Births? _____
- Number of Miscarriages? _____
- Number of Abortions? _____
Birth Control Method/s:
- Type _____
- How long? _____
- Type _____
- How long? _____
- Type _____
- How long? _____
Menopausal? __Yes __No
- Flushes (hot flashes)? __Yes __No
Date of Last PAP Test? ___/___/___
- Normal Results? __Yes __No
- Abnormal result? __Yes __No
Date of Last Mammogram? ___/___/___
- Normal Results? __Yes __No
- Abnormal Results? __Yes __No

Please feel free to add any more information to your medical history for Dr. Harandi.