Patient Past Medical History

Patient Name: _____DOB:_____Age:_____

Lifestyle History

1. Are you currently under the care of a physician? YES/NO
If YES, please explain?_____
2. Do you feel stressed? Explain_____
3. How many hours of sleep do you get each night?_____
4. Do you snore while you sleep? YES/NO_____Have you been diagnosed with sleep apnea? YES/NO
5. Do you get angry often? YES/NO
6. Are you happy? If not, explain_____
7. What worries you most?_____
8. Is your health important to you? Yes/No Most important reason to be healthy?_____
9. Who makes decisions regarding your health?_____
10. Do you currently have any medical concerns? Please List:_____

_____

Past History: (Please check if you have had any of the following):

☐ Allergies to medicines, foods_____ ☐ Birth defects or abnormalities
☐ Exposed to tuberculosis ☐ Rheumatic Fever ☐ Scarlet Fever ☐ Polio
☐ Diabetes: Type: _____
☐ Cancer, Type:_____
☐ Heart Disease:_____
☐ High blood pressure:_____
☐ Asthma or Lung disease:_____
☐ Thyroid Dysfunction:_____
☐ Polycystic Ovarian Syndrome:_____
☐ Cushing Disease or other endocrine diseases:_____
☐ Psychiatric Disorders (e.g. depression, anxiety, anorexia, bulimia):_____
☐ Other Diseases _____
☐ Operations: (dates) _____

Current Medications: (vitamins, birth control pills): _____
_____
_____
_____
_____

Menstrual History:

Date of last menstrual period _____Menstruation began at age:_____
Duration of bleeding:_____Pain with periods?_____
Amount of flow : Light _____ Med. _____Heavy _____
Bleeding between periods:_____Bleeding after intercourse:_____
Irritation or discharge:_____Itching or burning _____
Are you on birth control? (method): _____
Is there any chance you may currently be pregnant?_____

Family History:
Father: Health _____ Current Age _____ Deceased _____ at age _____ Cause _____
Mother: Health _____ Current Age _____ Deceased _____ at age _____ Cause _____
# of siblings:_____ # living_____ #deceased: _____ Cause _____

Family Diseases: Check diseases known in your blood relatives (not yourself)

☐ High blood pressure	☐ Heart trouble	☐ Anemia	☐ Obesity
☐ Migraine	☐ Bleeding (abnormal)	☐ Epilepsy	☐ Other _____
☐ Strokes	☐ Cancer	☐ Diabetes	
☐ Kidney disease	☐ Syphilis or (bad blood)	☐ Suicide	

Social History:
Single or married?_____Children?_____
Occupation?_____
Have you or do you currently smoke? _____ How much?_____ How many years: _____
Have you or do you currently drink alcohol?_____ Participate in illicit drug use?_____
Exercise/Hobbies?_____

Do you now have or have had any of the following?

☐ Trouble sleeping	☐ Previous MI	☐ Painful urination
☐ Fevers/chills/sweats	☐ Swelling of ankles/legs	☐ Urgency, hesitancy with urinating
☐ Fatigue/malaise/Tire easily	☐ Leg pains with walking	☐ Incontinence
☐ Rashes/itching	☐ Varicose veins	☐ Low back pain
☐ Dry skin, Acne	☐ Abdominal pain	☐ Irregular periods
☐ Hair loss, excessive hair growth	☐ Nausea or vomiting	☐ Infertility
☐ Headaches	☐ Gas or bloating	☐ Joint pains/Stiffness
☐ Dizziness	☐ Diarrhea or constipation	☐ Numbness/tingling
☐ Syncope/fainting	☐ Change in appetite	☐ Weakness/paralysis
☐ Visual changes	☐ Bleeding or black stools	☐ Sadness/nervousness
☐ Hearing changes	☐ Hernia	☐ Mood changes
☐ Difficulty swallowing	☐ Indigestion or heartburn	☐ Suicidal thoughts/actions
☐ Pain or stiffness (neck)	☐ Colitis	☐ Memory change
☐ Swollen, enlarged glands (neck)	☐ Jaundice	☐ Tremors
☐ Cough/Sputum Production	☐ Gallstones	☐ Hot or cold intolerance
☐ Shortness of Breath	☐ Gastric ulcers	☐ Easy bruising
☐ Lung disease	☐ Kidney stones	☐ Excessive bleeding
☐ Chest pain	☐ Pus or blood in urine	☐ Change in libido
☐ Palpitation or fluttering	☐ Bladder disease	

Examinations:
Date of last physical examination: _____ Reason:_____
Date of last laboratory tests:_____
Hospitalizations _____ Dates _____ Reason:_____
X-Rays: Chest _____ Date_____ Other_____
Electrocardiogram (heart tracing) _____ Date of last pap _____

Financial Policy:
Thank you for selecting Dr. Shah, MD/Stephanie Goede, PA-C for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements.

Patient's Signature Date

All Statements on this patient intake form are accurate and true to the best of my knowledge. I understand that treatments will be based on the information provided herein. If I willingly withhold knowledge from my treating physician, I accept full liability from any consequences arising there from.

Patient's Signature Date