PAREKH MEDICAL CLINIC

PATIENT MEDICAL HISTORY

Patient Name: _____

What is the purpose of your visit today?_____

_____

Past Medical History: High Blood Pressure, Asthma, Cholesterol, Heart Disease, Stroke, Cancer, Hepatitis, HIV, Kidney Disease, Chronic Pain, Diabetes, COPD, Psychiatric Illness, other_____ (please circle all that apply)

Significant Family History: _____

Surgical History and Dates: _____

Social History- please include whether you are employed, retired, or disabled.

If you are employed please include your place of work and title: _____

Married, Single, Divorced, or Widowed (please circle one)

Number of children: ____ Do you live alone? _____if not, who do you live with?_____

Do you need any assistance with your daily activities? _____Do you drink alcohol? _____

if so, how often per week? _____

Do you use any pain medications? _____ if so, what do you take? _____

Do you smoke? _____ how much per day? _____ when did you start smoking? _____

Do you have any other doctors that provide medical care for you? _____ if so, what is the doctor's name an specialty?
_____

Have you had a flu vaccine? _____ Pneumonia vaccine?_____ tetanus vaccine? _____

Are you currently on oxygen? _____ Are you currently on Home Health? _____

Have you ever had a colonoscopy? If so, when and what were the results?
_____

When was your last Pap smear and mammogram? _____

Have you ever had a bone mineral density test which checks for Osteoporosis? _____If so, when?
_____

What is the best way to contact you? By phone? By email? Or by mail? _____

Please give us your correct phone numbers and address. Please be willing to give us more than one contact number:

1. Phone: _____

2. Phone: _____