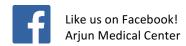


Arjun Medical Center, PC

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History Questionnaire

ne:	Date of Birth:	_ Date of visit:	
: M F Marital Status:	Email:		
t physical exam:	Occupation:		
son for today's visit:			
nily Health History			
ase indicate the major medical condition			
rt disease, high blood pressure, diabet		_	
• Father:			
• Mother:			
• Siblings:		-	
Children:			
<u></u>			
sonal Illness			
Please indicate if you have had any	of the following conditions	S:	
Alcoholism	Drug abuse	Liver disease, hepatitis	
Anemia	Easy bleeding	Measles, mumps, Rubella, or	
Asthma/emphysema/COPD	Eczema, hives, rashes	German measles	
Blood clots/Phlebitis	Epilepsy, seizures	Stroke	
Cancer, type:	Eye problems	Suicide attempt	
Chicken pox	Glaucoma	Thyroid disease	
Depression	Heart disease	Ulcer in stomach	
Diabetes	High blood pressure	Other:	
nunizations			
ele those that you have had and enter			
Pneumococcal:	Prevnar: Shi	ingles: l'étanus:	
disakian Allansia			
dication Allergies	f ! f -		
Please list the medication and type	e of reaction for each allergy	/.	

Hospitalization/surgery		
List illness or operations an	d approximate year.	Exclude all normal pregnancies.
Medications		
	ng hirth control vita	mins and other over the counter medications including
the doses if known. Use the	_	-
Other Medical History		
Current smoker?	Yes No	Former Smoker? Yes No
	If yes, what type:	Cigars/Cigarettes How many per day?
	Start year:	End year: or Total # years:
5 1:1 1 1:2		
Do you drink alcohol?	Yes No	Dana (Mina di incom
	• • • • • • • • • • • • • • • • • • • •	Beer/Wine/Liquor ow often? Daily/Weekly/Monthly
	HOW ITHACIT ATTA TIC	ow often: bany, weekly, worthing
Do you use other drugs?	Yes No	
Do you drink caffeine?	Yes No	How many cups per day?
Do you exercise?	Yes No	
	What types?	
	How many times	per week?
For Momor Only		
For Women Only # of pregnancies ##	of live horn children	# of Premature births
# miscarriages #		# OF Femalure births
Date of last Pap smear:		'Abnormal
Date of last Mammogram:		
Current Symptoms		
Please check the symptoms	s below that current	
Itchy or burning skin		Frequent night time urination Black, brown or bloody urine
Dry or flaky skin Prolonged bleeding		Loss of control of urine
Easy bruising		Difficulty starting to urinate
Fainting or feeling lightheade	d	Feeling of not completely emptied the bladder
Numbness in any part of the body		Stiff or painful muscles or joints
Recent changes in handwriting		Swollen joint(s)
Shaking or trembling of hands		Changes in bowel movements

Nervous around strangers	Bleeding from the rectum
Difficulty making decisions	Back or shoulder pain
Difficulty with concentration or memory	Painful feet
Often feel lonely or depressed	Headaches more than once a week
Cry often	Pain with movement of the neck
Hopeless outlook	Cataracts
Sexual difficulties	Vision problems
Thoughts of committing suicide	Hearing difficulty
Desired or sought psychiatric help	Motion sickness in cars or planes
Weight loss or gain	Dental problems
Are you often too hot or too cold?	Changes in taste
Decreased interest in eating	Stuffy or runny nose
Do you always seem to be hungry?	Head cold for 2 or more months
Increased thirst	Nose bleeds
Swellings in your armpits or groin	Sore throat without a cold
Are you exhausted or fatigued most of the time?	Enlarged tonsils
Difficulty falling or staying asleep	Hoarse voice
Snore at night	Wheezing
Wake up still tired after a full night of sleep	Coughing spells
Frequently sleep during the day	Coughing blood
Fall asleep quickly at night	Frequent sweating or night sweats
Teeth grinding during sleep	High blood pressure now or in the past
Frequent kicking or movements during sleep	Thumping or racing heart
Heartburn	Chest pain or tightness
Feel bloated after eating	Dizziness or lightheadedness
Frequent belching	Shortness of breath
Stomach discomfort	Waking up at night feeling short of breath
Frequently nauseated	Swollen feet or ankles
Ever vomited blood	Leg cramps at night or with walking
Difficult or painful swallowing	Heart murmur
Men only	Women Only
Weak or slow urine stream	Bleeding after menopause
Enlarged prostate or other prostate problems	Heavy bleeding with periods
Burning or discharge from the penis	Bleeding between periods
Swelling or lumps in the testicles	Bleeding after intercourse
Painful testicles	Vaginal itching or discharge
Difficulty getting or maintaining an erection	Lumps or pain in breasts
	Complications with birth control
	Sexual difficulties
	Abnormal Pap smears or mammogram