AHMAD MUR, MD
JAYSHREE BHASKARA, MD

H&P

Date:__/__/____ Name:_____ Date of Birth:__/__/_____
Reason for Visit:_____

Sex: ☐Male ☐Female
Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated
Height: ____ ft ___ in Weight _____ lb
Phone: Personal (___)-___-____ Business (___)-___-____ (can we leave phone message: ☐Yes ☐No)
Address:_____

Family History: IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING – PLEASE INDICATE WITH ✓ AND INDICATE WHICH RELATIVE

☐ Epilepsy / Seizures: __	☐Osteoporosis:_____	☐Cancer:_____
☐Migraine: _____	☐Arthritis:_____	☐Depression:_____
☐Diabetes Mellitus: ____	☐Heart Disease:_____	☐Alcoholism:_____
☐Thyroid Disease: _____	☐Stoke:_____	☐Mental Illness:_____
☐Hay Fever / Asthma: __	☐Hypertension:_____	
☐Anemia:_____	☐Lipid Disorder:_____	
☐Bleeding Disorder:____	☐Hepatitis:_____	

Past Medical / Past Surgical History / Hospital Admissions: (Please list all)

List all **Medications** you take (including those you buy without prescription)

1:_____	6:_____	**Allergies**:
2:_____	7:_____	1:_____
3:_____	8:_____	2:_____
4:_____	9:_____	3:_____
5:_____	10:_____	4:_____

Social History: Do you smoke now or did in the past: **Yes / No** Do you drink alcohol now or did in the past: **Yes / No** Do you drink Coffee? **Yes/No** Do you have Advance Directives: **Yes/No**

Review of Systems: Indicate problems with a ✓

General: ☐No Problems ☐ Fever ☐ Malaise / Fatigability ☐Night Sweats ☐ Weight Loss ☐Weight Gain ☐_____

Dietary: ☐No Problems ☐Change in appetite ☐Problems with Solid Food ☐ _____

Musculo-skeletal system ☐No Problems ☐Joint Stiffness / pain ☐Joint Swelling ☐ Joint Redness ☐Joint Deformity ☐_____

Head-Neck-Eyes-Ears ☐No Problems ☐Headache ☐Loss of consciousness ☐Glaucoma ☐Glasses ☐Blurred Vision ☐Double Vision ☐Legally Blind ☐Glaucoma ☐_____

ENT: ☐No Problems ☐Hearing Loss ☐Ringing in ears ☐Frequent Colds ☐Nose Bleeds ☐Postnasal discharge

AHMAD MUR, MD
JAYSHREE BHASKARA, MD

H&P

Patient Name: _____ **DOB:**_____

Throat – Mouth: ☐No Problems ☐Hoarseness ☐Sore throat ☐Bleeding gums ☐Mouth ulcers ☐Tooth problems ☐_____

Skin: ☐No Problems ☐Rash ☐Itching ☐Ulcers / Wound☐_____

Endocrine: ☐No Problems ☐Thyroid problems ☐Blood sugar problems ☐Heat-cold intolerance ☐_____

RS/CVS: ☐No Problems ☐Cough ☐Shortness of breath ☐Wheezing ☐Coughing blood ☐Chest pain ☐High blood pressure (bp) ☐Unable to lay flat ☐Palpitations ☐Leg Swelling / Edema ☐_____

GI: ☐No Problems ☐Trouble swallowing ☐Heartburn ☐Nausea ☐Vomiting ☐Vomit blood ☐Constipation ☐Hemorrhoids ☐Blood in stool ☐Jaundice ☐Gallstones ☐Abdominal Pain ☐Polyp ☐Diarrhea ☐_____

GU: ☐No Problems ☐Dark Urine ☐Frequent urination ☐Burning with urination ☐Blood in urine ☐Hesitancy ☐Incontinence ☐_____

CNS: ☐No Problems ☐Seizures ☐Weakness ☐Coordination problems ☐ Abnormalities of sensation ☐ Tremors ☐Memory Loss ☐Anxiety ☐ Depression ☐Sleep Disturbance ☐Marital / Sexual problems ☐_____

Females Only: Menstrual Flow: ☐Regular ☐Irregular ☐Pain / Cramps
Days of Flow: _____ Length of Cycle:___ First day of Last Period:___
No. of pregnancies / Abortions: ____ Birth Control:_____
Date of Last Pap: ___/___/_____ Date of Last Mammogram: ___/___/_____

Vaccination Status: Up-to-date: **Yes/No** ☐Tetanus ☐Diphtheria ☐Whooping Cough ☐FLU ☐MMR ☐Hepatitis _ Date of Last TB Test: __/__/____

Please list any other symptoms or concerns:_____

_____

Reviewed with:_____ on:__/__/____ Signature:_____