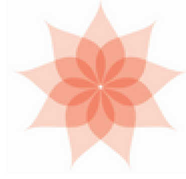

HEALTH HISTORY

Name: ____ Date: ______________________________

SYMPTOMS: Please check any symptoms you have recently experienced:

□ Fever/Chills □ Weight loss □ Fatigue □ Weakness □ Pain (identify location) ______________

MEN ONLY: □ Breast lump □ Lump in testicles

WOMEN ONLY: □ Abnormal pap smear □ Breast lump □ Bleeding between periods □ Nipple discharge

Date of last menstrual period: ________ Last mammogram: _________ Could you be pregnant? _____

CONDITIONS: Please list ALL medical conditions:

□ Arthritis □ Asthma □ Anxiety □ Bleeding disorders □ Chest pain □ COPD □ Depression

□ Diabetes □ Excessive bruising □ Glaucoma □ Heart attack □ High blood pressure □ HIV/AIDS

□ Kidney disease □ Liver disease □ Pacemaker □ Palpitations □ Reflux □ Seizures □ Sickle cell anemia

□ Sleep apnea □ Stroke □ TB □ Thyroid problems □ Ulcer □ Urinary problems □other_____________

MEDICATIONS: Include over the counter medications, vitamins, and herbs: ________________________

____

ALLERGIES: ____

PRIOR SURGERY OR HOSPITALIZATIONS:

Year	reason for hospitalization	outcome

HEALTH HABITS:

Do you currently smoke? □ yes □ no _______packs per day x _____ years Quit? □ yes □ no
Do you drink alcohol? □ yes □ no If yes, how often? _____________
Do you have any history of substance abuse? □ yes □ no

Primary care physician: __________________________________ Telephone: ______________________

I certify that the above information is correct to the best of my knowledge. I will not hold Dr. Naidu or members of her staff responsible for errors or omissions that I may have made in the completion of this form.

___________________________ ____________ __________________________

Signature Date Nina S. Naidu, M.D.