Patient Name: _____ Age_____

As required by law, the office needs to know the following pieces of information. Please Circle the most appropriate response to the background questions:

Race:

| | | |
|---|---|---|
| Asian | Islander | American Indian |
| Black/African American | Alaskan Native | Other |
| Native Hawaiian/Pacific | White | Refuse to answer |

Ethinicity:
Latino Non-Latino Refuse to answer

Language:
English Spanish ASL Other_____

Height:_____ Weight: _____

Primary Pharmacy:_____

Address: _____

Phone #:_____

Who referred you to come and see Dr. Gupta? _____ Handedness: R L

Please list address & phone#: _____

Is this Dr. currently treating you? Y / N
If No, what doctors have treated you to date? _____

## Chief Complaint

Reason for visit today (brief explanation) _____

_____.

Is this the result of an injury? Y / N: If yes, please explain: _____

Current Medication: Dose Reason for Meds

_____

_____

Any Drug Allergies? (please list): _____

## Review of Systems:

Are you currently having or have you had problems with any of the following? (circle all that apply)

| | | | |
|---|---|---|---|
| Diabetes | Balancing problems | Immune Disease | Polio |
| Insulin Dependency | Numbness/tingling | (Viral/ Auto) | TB Epilepsy |
| High Blood Pressure | Black-out/fainting | Cancer | Heart Disease |
| Bleeding problems | Psychological | Arthritis | |

Patient Name: _____

| Surgeries/Hospitalizations (Please list) | Year | Complications |
|---|---|---|
| | | |
| | | |

Have you ever had general anesthesia? Yes ___ No ___
Have you ever had any problems with anesthesia? Yes___ No ___

If yes, please describe: _____

## Family History

Please list any significant medical history in your immediate family i.e.: arthritis, cancer etc: &member relation:

_____

## Social History

Do you exercise? __ Daily __ Weekly __ Monthly __ Rarely __ Never

If yes, what type of exercise? _____

Any history of substance abuse? __ Yes __ No __ If yes, to what? _____

Do you Smoke currently? __Yes __ No ___ Packs per day ____ # of years

Quit Smoking? __ This year __ >1yr __ >5 yrs __ >10 yrs

Do you drink Alcohol? __ Daily __ 1-2x/week __ 1-2x/month __ 1-2x/yr

Have you had flu shot with in the past 6 months? Yes or No

Have you had a foot exam in the past 6 months? Yes or No

Have you had pneumonia immunization with in the past year? Yes or No

Patient signature: _____ Date: _____

Reviewed by: _____ Date: _____

(DR. SALIL GUPTA)