Sant P Chawla, M.D.
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MEDICAL HISTORY QUESTIONARE 1 of 3

Pateint Name: _____ **DOB:** _____ **Date:** _____

Please check if you have or had problems with any of the following:

General ◯ Fatigue ◯Fever ◯Weakness ◯ Dizziness ◯Weight Loss ◯Weight Gain ◯Appetite Loss

Skin: ◯ Rash ◯ Itching ◯ Hives

Nervous System ◯ Headache◯ Visual Changes ◯ Numbness ◯ Strength Changes ◯ Seizures ◯ Stroke

Ear, Nose, Throat ◯ Ear Pain ◯ Throat Pain ◯ Discharge ◯Glaucoma ◯ Eye Problems ◯ Hearing Loss

◯ Emphysema ◯ Tuberculosis ◯ Asthma

Respiratory/Heart ◯ Shortness of Breath ◯Chest Pain ◯Cough ◯Phlegm ◯ High Blood Pressure ◯Heart Disorders

Stomach/Digestion ◯ Heart Burn ◯Stomach Swelling ◯ Pain Swallowing ◯ Stomach Pain ◯ Diarrhea ◯ Constipation

◯ Acid Reflux ◯ Ulcers ◯Diabetes ◯ Nausea / Vomiting

Urinary System ◯ Pain (urinating) ◯ Blood in urine ◯ Excessive Urination ◯ Pain in Lower Back (kidney area)

Muscle/Joints ◯Back Pain ◯ Joint Pain ◯ Joint Swelling ◯ Joint Stiffness

Blood/Glands ◯ Anemia ◯ HIV ◯Thyroid Disease ◯ Easy Bruising/Bleeding ◯ Immune Deficiency

Psychological ◯ Depression ◯Anxiety ◯ Psychiatric Disorders ◯ Feeling of Grief/Sadness

Gynecological) (women only) ◯ Irregular Bleeding ◯ Irregular/Smelly Discharge ◯ Pain

Other(s): _____

For **EACH** of the above marked problems please list the following: (if extra space is needed please continue on back)

Problem	Date Problem Began **must fill in***	Date Ended (if current write current)	Have you been treated?

Do you smoke? ◯No ◯Yes If no, when did you quit? _____ If yes, how many packs a day?_____ For how many years?_____

Do you drink alcohol? ◯ No ◯ Yes How many drinks per week? _____

Do you use recreational drugs? ◯ No◯ Yes List all: _____

Do you experience pain as part of your daily life? ◯No ◯Yes Where is Pain located? _____

If yes, on a scale from 1-10, describe this pain: _____

How do you treat this pain? _____

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MEDICAL HISTORY QUESTIONARE 2 of 3

Cancer History:

Primary Diagnosis: _____ **Initial Date Diagnosed**: _____

List all treatment(s) tried and failed as well as dates for each:

_____

_____

Metastasis : _____ **Date Diagnosed**: _____

Are you currently being treated? _____

List treatment you are currently on:

_____

Are you or have you been on a clinical trial? ◯ Yes ◯ No

If yes please list names and dates of each: _____

_____

Family History:

Please list all Illnesses in Family (ie: stroke, cancer, diabetes etc…) and who currently has the illness.

Illness	Who?	Illness	Who?

Current Prescription Medications:

Name of Drug	Strength (mg, mcg, grams)	Frequency (ie one a day)	Start Date

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MEDICAL HISTORY QUESTIONARE 3 of 3

Are you currently taking aspirin, Ibuprofen or other blood thinners? YES / NO If yes please list add to above list (s) above ↑.

Allergies to Medication: ☐ No ☐ Yes If yes, please list: _____

Past surgeries and hospitalizations: (Use the reverse side if more space is required.)

Date: _____ **Illness/Surgery** _____ **Hospital/Facility:** _____

Date: _____ **Illness/Surgery** _____ **Hospital/Facility:** _____

I certify the above medical history is true and correct to the best of my knowledge:

Signed: _____ Print Name: _____ Date: _____