One Sears Drive, Suite #402

Paramus, NJ 07652

☎: 201-483-9188

Fax: 201-483-9189

Amit Agarwal MD PC

Sonia Chadha MD

NEW PATIENT COMPLETE HISTORY FORM **DATE: ___________**

A. **PERSONAL HEALTH HISTORY**:

1. **List all Operations and Dates:**

	OPERATION	DATE	WHERE PERFORMED	DOCTOR
1				
2				
3				
4				
5				
6				

Past Medical History (check ✓ any you have had)

☐ Measles ☐ German Measles ☐ Diphtheria ☐ Heart Disease
☐ Mumps ☐ Diabetes ☐ Rheumatic Fever ☐ Kidney Disease
☐ Alleged Abuse ☐ Physical or Mental Disability

List below any major injuries, broken bones or hospitalizations not listed above. Also, list any major or chronic illnesses you have at present or have had, (i.e. arthritis, high blood pressure, nervous condition, seizures, etc.)

	ILLNESS	APPROXIMATE DATES
1		
2		
3		
4		
5		
6		

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2. Children:

				WOMEN ONLY	
	DATES OF BIRTH	SEX	HEALTH PROBLEMS	BIRTH WEIGHT	PROBLEMS WITH PREGNANCY or DELIVERY
1					
2					
3					
4					
5					
6					

3. Menstrual History (Women Only)

A. Age of onset: ___________________

B. Usual Cycle every __________ days/weeks x _______________ days

C. Present Contraception ______________________________________

Obstetrical History Para ____________________

Significant Complications ____

____

Previous Mammogram Yes No If Yes, Date ___________________

Previous Pap Smear Yes No If Yes, Date ___________________

Previous Abnormal Pap Smear Yes No If Yes, Date ___________________

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B. FAMILY HISTORY:

FAMILY MEMBER	IF LIVING			IF DECEASED		
	AGE	CONDITION OF HEALTH FAIR OR POOR	HISTORY OF ALLERGY, DIABETES, CANCER, EPILEPSY, HEART DISEASE, HYPERTENSION, MENTAL ILLNESS, T.B. ETC	DATE	AGE AT DEATH	CAUSE
Father						
Mother						
Brothers						
Sisters						
Paternal Grandfather						
Paternal Grandmother						
Maternal Grandfather						
Maternal Grandmother						
Others, specify						

C. IMMUNIZATION RECORD:

	DATE
Diphtheria	
Tetanus	
Pertussis	
Polio	
Hepatitis A	
Measles	
Rubella	
Hepatitis B	
Pneumovax	
Mantoux	
Result	
Influenza	

ALLERGIES: To medications, food, and contact. Please list all.

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PERIODIC INTAKE FORM:

This is a confidential questionnaire. Answer it to the best of your ability. If you are in doubt about an answer, pencil in a question mark (?). This is designed for your benefit and your efforts in completing it will help us give you the best possible medical care.

1. LIST CONCISELY SPECIFIC SYMPTOMS OR PROBLEMS YOU WANT INVESTIGATED ON THIS EXAM:

1.
2.
3.
4.
5.

2. List all medications – pills or liquid presently being taken – including vitamins, minerals, or other nutritional supplements.

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

3. Are you on a special diet? ☐ Yes ☐ No If yes, what kind? _____________
4. Occupation: ☐ Full-Time ☐ Part-Time Hours per week: ________
5. Describe briefly what you do on your job: _______________________________________
6. Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow(er)
7. Who lives in your household? ____
8. Have you traveled abroad in the past year? ☐ Yes ☐ No

   If yes, destination ______________________________

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9. Habits (indicate amount consumed of the following):

1. Cigarettes/smokeless _________________________ packs/day
2. Cigars or pipe loads _________________________ per day
3. Coffee __________________ cups/day
4. Cola Beverages ________________ bottles/cans per day
5. Cocktails or straight drinks ___________ per week
6. Beers (3.2% or stronger) _________ per week
7. What % of time in your vehicle do you wear seat belts? ____________ %

10. Method of Birth Control (if applicable) ______________________________________

11. Exercise (for example: walking, jogging, golf, tennis, handball, calisthenics etc.):

TYPE	NUMBER OF TIMES PER WEEK

12. WOMEN ONLY:

Menstrual Periods: ☐ Heavy ☐ Average ☐ Light

Last Menstrual Period ________________

Interval between periods ______ Days of flow _________________

13. Do you have any sexual concerns you wish to discuss? ☐ Yes ☐ No

If yes, please provide a brief description: ____________________________________

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14. Educational Needs:

☐ Yes	☐ No	Patient is aware of diet, exercise and lifestyle conducive to osteoporosis prevention
☐ Yes	☐ No	Patient is aware of need for monthly breast self-exam and proper technique
☐ Yes	☐ No	Patient is aware of importance of protection against STDs by monogamy or "safe sex"
☐ Yes	☐ No	Patient is aware of current recommendations for routine mammogram and Pap Smears
☐ Yes	☐ No	Patient is aware of importance of seatbelt use

15. CHECK SYMPTOMS TO WHICH YOU ARE SUBJECT:

☐ Blurred Vision	☐ Swelling of Legs	☐ Dribbling
☐ Eye pain	☐ Pain in legs with exercise	☐ Need to void more than once at night
☐ Deafness	☐ High blood pressure	☐ Blood in urine
☐ Ringing in ears	☐ Positive TB (Mantoux) skin test	☐ Loss of force of stream
☐ Hay fever	☐ Loss of appetite or weight	☐ Spotting with intercourse
☐ Nosebleeds	☐ Special diet	☐ Painful intercourse
☐ Sinus infections	☐ Constipation	☐ Vaginal discharge
☐ Hoarseness	☐ Heartburn	☐ Urethral discharge
☐ Difficulty swallowing	☐ Gaseousness	☐ Frequent headaches
☐ Excessive thirst	☐ Pain in abdomen	☐ Dizziness
☐ Asthma (Wheezing)	☐ Vomiting	☐ Numbness
☐ Persistent cough	☐ Diarrhea	☐ Nervousness
☐ Blood phlegm	☐ Black or bloody stools	☐ Insomnia
☐ Shortness of breath with flight of stairs	☐ Distress from spicy or fatty foods	☐ Convulsions
☐ Shortness of breath at night	☐ Change in bowel habits	☐ Fainting spells
☐ Chest pain with cough	☐ Frequent voiding (passing urine)	☐ Crying spells
☐ Chest discomfort with exercise	☐ Painful voiding	☐ Joint pains
☐ Palpitation	☐ Urgent voiding	☐ Back pains

Use lines below for further explanation of any symptoms checked above:

____

____