Dr. Himanshu P. Parikh
Patient History

Date _______________

Name ____ Date of birth __________________

Reason for visit ____

HOSPITALIZATIONS If you have been in the hospital overnight, starting with the most recent, state the year, illness/operation.			
YEAR	**ILLNESS/OPERATION**	**YEAR**	**ILLNESS/OPERATION**

PAST MEDICAL and FAMILY HISTORY Check if you or any blood relative has any of the following conditions.					
	SELF	**RELATION**		**SELF**	**RELATION**
Allergy/Asthma			High Cholesterol		
Alcohol/Drug Abuse			Liver Disease		
Anemia			Lung Disease		
Anxiety/Depression			Mental Illness		
Arthritis			Obesity		
Blood Disorder			Osteoporosis		
Cancer			Stomach/Intestinal		
Childhood Disease			Seizure		
Diabetes			Stroke		
ENT Disorder			Thyroid Disease		
Headache			Ulcer		
Heart Attack			Urological/Bladder		
Heartburn/Reflux			Weight Gain/Weight Loss		
Heart Disease			Other		
High Blood Pressure					

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING		
MEDICATION/DOSE/TIMES	**MEDICATION/DOSE/TIMES**	**MEDICATION/DOSE/TIMES**

DO YOU NOW OR HAVE YOU EVER CONSUMED?				
Cigarettes	☐ Yes	☐ No	Pack/Day	# Years
Alcohol	☐ Yes	☐ No	Drinks/Wk	
Coffee/Tea	☐ Yes	☐ No	Cups/Day	
Street Drugs	☐ Yes	☐ No	Type	
Exercise	☐ Yes	☐ No	Min/Day	Times/Week

DRUG ALLERGIES	
DRUG	**REACTION**

THE LAST TIME YOU HAD A (YEAR)			
Flu Vaccine		Tetanus Shot	
Hepatitis Vaccine		Pneumonia Shot	
T.B. Test		Rectal Exam	
Stool Blood Test		Eye Exam	
Dental Exam		Colonoscopy	
Cholesterol Test			

FOR WOMEN ONLY		
Date of Last Period		
Birth Control	☐ Yes	☐ No
Type		
Number of Pregnancies		
Number of Births		
Number of Abortions		
Number of Miscarriages		
YEAR OF LAST		
Pap Test	☐ Normal	☐ Abnormal
Breast Exam	☐ Normal	☐ Abnormal
Mammogram	☐ Normal	☐ Abnormal

Date of last complete physical: ___________________________

Do you have any other problems for which you have been seeing a doctor on a regular basis? Please list them. ____

Do you currently see a dentist, if yes, name? _______________ Psychiatrist? ____________________

Are you having any symptoms you would like to discuss? Please list them. ______________________

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Chart #__________________________