DHARMAVIJAYPAL REDDY NARAYAN M.D.

Referred by: Name:____ TODAY'S DATE:____________________

Patient Information Form (Please Print)

PATIEN T

☐ Single
☐ Married
☐ Divorced
☐ Widowed
☐ Other

Last **First** **MI** | **Date of Birth** **Age**

Address **City** **State** **Zip**

Sex: ☐ Male ☐ Female | **Are you a student?** **Yes** ☐ **No** ☐

Street Address (if different from mailing) | **City** **State** **Zip**

Phone (Home) | **Employer's Phone #**

Phone (Mobile)

Preferred Method of Contact?

Email:

Spouse's Name | **Date of Birth**

ADDITIONAL INFORMATIO N

Race: ☐ American Indian or Alaska Native ☐ Black ☐ White ☐ Hispanic ☐ Other ☐ Decline to Answer

Ethnicity: ☐ Hispanic ☐ Non-Hispanic | ☐ English ☐ Spanish

Name of your Pharmacy **Address**

City **State** | **Phone #**

RESPONSIBLE PART Y

☐ Self
☐ Spouse
☐ Guardian
☐ Other

Last **First** **MI** | **Phone Number:**

Address

City **State** **Zip**

IN CASE OF EMERGENCY NOTIFY

Name | **Relation**

Address | **Phone #**

INSURANCE INFORMATION

Primary Insurance

Policy Contract # | **Group #** | **State** **Zip**

Name of Policy Holder

Secondary Insurance

Policy Contract # | **Group #** | **State** **Zip**

Name of Policy Holder

DHARMAVIJAYPAL REDDY NARAYAN M.D.

Date:___________________________

PATIENT INFORMATION FORM

Patient's Name: ____________________________ Guardian's Name (if under 18): _____________________________

ALLERGIES TO MEDICATIONS or ENVIRONMENTAL

Medication or Other (Environmental)	Reaction

FAMILY HISTORY

(Please check if your family has a history of any of these diseases)

Condition	Mother	Father	Maternal Grandparents	Paternal Grandparents	Brother	Brother	Sister	Sister	Additional Sibling(s)
Cancer									
Diabetes									
Heart Attack									
High Blood Pressure									
High Cholesterol									
Stroke									
Other									

If your mother, father, brothers, or sisters are deceased, please list their age at the time of their death and the cause:

Relationship	Cause of death	Age at death	Relationship	Cause of death	Age at death

YOUR HEALTH HISTORY

(Check if you have had any of the following)

	Abnormal Heart Rhythm		Chronic Pain		Heartburn/GERD		Obesity
	Allergies (any)		Chronic Kidney Disease		Heart Murmur		Osteoporosis
	Anemia		Depression		Hepatitis		Peripheral Vascular Disease
	Anxiety/Stress		Diabetes		High Blood Pressure		Seizures/Epilepsy
	Asthma		Emphysema/COPD		High Cholesterol		Sleep Apnea
	Arthritis		Gallbladder Disease		HIV/AIDS		Stomach Ulcers
	Atrial Fibrillation		Gout		Irritable Bowel Syndrome		Stroke
	Colitis or Crohn's Disease		Headaches/Migraines		Kidney Failure		Thyroid Disease
	Cancer		Heart Attack/Failure		Kidney Stones		

PREVENTATIVE HEALTH HISTORY

Check if you have had any of the following preventative health screening exams (month/year)

Test	Date	Results	Physician
Colonoscopy			
Cholesterol Screening			
Cardiac Stress Test			
Bone Density			
Mammogram			
Breast Exam			

Vaccine Type	Date
Tetanus (Td)	
Pneumonia	
Hepatitis B	
Influenza (Flu)	
Shingles	
Other	

OB/GYN HISTORY

Number of Pregnancies Number	
of full term babies Number of	
premature babies Number of	
abortions/miscarriages Number of	
living children	

ACCIDENTS - TRAUMA:

Have you ever had a severe accident? YES NO Do you have any metal pins/plates in your body? YES NO **If yes, please describe**

DHARMAVIJAYPAL REDDY NARAYAN M.D.

NAME:____ Date:______________

PAST SURGICAL HISTORY

Date	Surgery	Date	Surgery

Please List Any Additional Medical Information:

____

HEALTH HABITS HISTORY

Do you now/have you ever smoked? YES NO (circle one) If yes, how long have/did you smoke? ___ How many packs per day? ___

Did you quit? YES NO (circle one) If yes, what year did you quit? _______

How many alcoholic beverages do you drink per week? _______ How many days per week do you exercise? _______

In the past 6 months, have you had a regular problem with pain? YES NO Where? Do you wear glasses/corrective lenses? YES NO Do you wear a hearing aid? YES NO

Do you use any of the following equipment?

Device	Yes/No	Device	Yes/No	Device	Yes/No
Cane		Walker		Bi-pap (sleep apnea)	
Electronic Scooter		Wheelchair		C-pap (sleep apnea)	

Do you follow a healthy diet? YES NO (circle one) Please describe what type of diet you follow - well-balanced, low carb, low fat, etc.

LIST *ALL* PRESCRIPTION MEDICATIONS, VITAMINS, AND HERBAL SUPPLEMENTS

Name	Dose	Frequency	Ordering Provider

PHYSICIANS LIST

(Please list any other physicians currently assisting in your care)

Specialty	Physician	Specialty	Physician	Specialty	Physician
Allergy/Immunology		Hematology		Pain Management	
Cardiology		Nephrology		Podiatry	
Chiropractor		Neurology		Psychiatry/Mental Health	
Dental		OB/GYN		Pulmonary Medicine	
Dermatology		Oncology		Rheumatology	
Endocrinology		Ophthalmologist		Sleep Medicine	
Gastroenterology		Optometrist		Urology	
General Surgery		Orthopedics		Other Specialty	

Do you have an advance directive/living will? **YES NO (circle one)**

If yes, please supply the office with a copy for your chart. If no, would you like one? **YES NO (circle one)**