PATIENT INFORMATION

First Name:	Last Name:	
Date of Birth:	Soc Sec #:	
Address:		
Home Phone:	Cell:	Work:
Email Address:		
Sex: Male or Female		
Ethnicity:	Race:	Language:

Emergency Contact Name:
Relationship To Patient:
Emergency Contact Phone Number:

Preferred Pharmacy Name:
Pharmacy Address:
Prescription Company Coverage Name:

Health Insurance Company Name:
Insurance ID#:
Employer:

***PLEASE MAKE SURE TO SWITCH YOUR PCP TO DR. RAZA MAMDANI, M.D. BEFORE YOUR VISIT TO OUR OFFICE. PLEASE HAVE ALL PAPERWORK FILLED OUT COMPLETELY BEFORE RETURNING TO STAFF. YOU MUST BRING YOUR INSURANCE CARD WITH YOU TO YOUR APPOINTMENT OR YOU WILL NOT BE SEEN. PLEASE ARRIVE 10 MINUTES BEFORE YOUR APPOINTMENT TIME.**

PATIENT HISTORY

Medical Problems (please explain "yes" answers)

	Yes	No	Explanation
Heart Disease			
Lung Disease			
Kidney Disease			
Strokes			
Seizures			
Bowel Problems			
Problem Urinating			
Diabetes			
High Blood Pressure			
Liver Problems			
Gallbladder			
Blood Clots			
Ulcers			
Cancers			
Thyroid Problems			
Vision/Hearing Problems			
Other			

Surgical History

Procedure/Operation	Date	Surgeon/Hospital

Medications (Prescribed & Over the Counter)

Name of Medication	Dosage	Times Per Day

Allergies

Medication Name/Food	Type of Reaction

Family Health History

Father	Alive Age	Deceased Age	Cause of Death	Medical Problems
Mother	**Alive Age**	**Deceased Age**	**Cause of Death**	**Medical Problems**
Brothers/Sisters	**Medical Problems**	**Causes of Death**		

Gynecologic History

Name of Gynecologist		
Are Your Periods Regular?		
Date of Last Period		
Menopausal Status		
Date Of Last Pap Smear		
Date Of Last Mammogram		
Number of Children	Boys:	Girls:
Number of Vaginal Deliveries		
Number of Cesarean Sections		
Total Number of Pregnancies		

Do You Have A Health Care Proxy Signed? _____Yes _____No

Do You Have A Power Of Attorney? _____Yes _____No

Do You Have A DNR (Do Not Resuscitate Order)? _____Yes _____No

Habits

Tobacco

Never Smoked			
Quit Smoking	Age Started:	Age Stopped:	Packs Per Day:
Currently Smoke	Packs Per Day:	For How Many Years?	
Do You Smoke Cigarettes?	Pipe?	Cigar?	Chew Tobacco?
Have You Tried To Quit Without Success?	Do You Want To Quit?		

Alcohol

Never Drink		
Quit Drinking	When?	
Do You Drink Weekly?	Type & Amount?	
Do You Drink Daily?	Type & Amount?	

Drugs

Never Used Drugs				
Quit Using Drugs	When?			
Present Drug User Of:	Marijuana?	Cocaine?	Heroin?	PCP?

Habits

Exercises

Never Exercise	
Rarely Exercise	
Regularly Exercise	# Of Days Per Week:

Caffeine

Coffee	Amount:
Tea	Amount:
Other	Amount:

Sexual History

Marital Status	Married?	Divorced?	Single?	Separated?
#Of Previous Marriages:				
Orientation	Heterosexual?	Homosexual?		
#Of Partners In The Last 2 Years:				
Type Of Contraception:				