CLAREMONT
MEDICAL CENTER

Please be complete honest. This information is strictly confidential and used only by the doctor to evaluate and treat your medical condition.

Patient's Name: _____

I hereby authorize the physician or their representative to leave laboratory results on my (circle all that apply):

Home answering machine / voicemail / Cell phone / Email

Are you allergic to any medications? Yes No If yes, List: _____

List all medications you are currently taking (please include any prescription, over the counter, vitamins, herbals, etc)

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Past medical history

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Cancer (type) _____
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS
- ❑ Arthritis/Joint deformity

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?
- ❑ Artificial Joints?

Where?

EYES
- ❑ Dryness
- ❑ Pain
- ❑ Loss of vision
- ❑ Double or blurred vision

HEART AND LUNGS
- ❑ Pacemaker/ Artificial valve
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Blood in stool or black stool

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

SKIN
- ❑ Redness
- ❑ Nodules/bumps
- ❑ Hair loss

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

Women Only:
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

PSYCHIATRIC
- ❑ Depression
- ❑ Anxiety
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Poor appetite
- ❑ Frequent crying
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability

Other

FAMILY MEDICAL HISTORY
- ❑ Diabetes
- ❑ Heart Disease
- ❑ Asthma
- ❑ Thyroid disorder
- ❑ Cancer (type) _____
- ❑ Mental Illness
- ❑ Bleeding Disorder
- ❑ Kidney Disorder
- ❑ High BP
- ❑ High Cholesterol
- ❑ Stroke

See Reverse

CLAREMONT
MEDICAL CENTER

WOMEN'S REPRODUCTIVE HISTORY:

Pregnancies:

Miscarriages:

Abortions:

Have you reached menopause? Y / N At what age?

Do you have regular periods? Y / N

SCREENING:

When was your last Pap smear? _____

When was last Mammogram? _____

When was last Colonoscopy? _____

Do you smoke? Yes / No if yes, how many cigarettes per day _____

Do you drink alcohol? Yes / No if yes, how many drinks per day _____

Do you use Illicit drugs? Yes / No if yes, what? _____ How much? _____

What's your occupation? _____

All Patients: The above information is accurate and complete to the best of my knowledge. I understand that it is my obligation and responsibility to notify Dr. Mohitkumar Ardeshana and staff of any changes in my medical condition or medications during the course of my medical treatment.

Patient Signature: _____ Date: _____

Reviewed by: _____