TAMPA BAY reflux INSTITUTE

NAME (LAST, FIRST, M.I.):					
GENDER	☐ MALE	☐ FEMALE	☐ TRANS MALE	☐ TRANS FEMALE	DOB:
WEIGHT:	HEIGHT	(OFFICE USE ONLY): BP: PULSE			

PRIMARY COMPLAINT: _____
HOW SEVERE IS THE PAIN/ PROBLEM? _____
WHAT OTHER SIGNS OR SYMPTOMS ARE YOU HAVING? _____
HOW LONG HAVE YOU HAD THIS PAIN/ PROBLEM? _____
WHAT MAKES THE PAIN OR PROBLEM WORSE? _____
HAVE YOU HAD ANY PREVIOUS EPISODES? _____
HAVE YOU HAD PRIOR STUDIES? IS YES WHAT KIND? _____

MEDICAL HISTORY	
☐ HIGH BLOOD PRESSURE ☐ HEART ATTACK ☐ ATRIAL FIBRILLATION ☐ STROKE ☐ DIABETES ☐ KIDNEY DISEASE ☐ CANCER	☐ THYROID DISEASE ☐ HEARTBURN ☐ ASTHMA ☐ COPD ☐ HEPATITIS A, B, OR C ☐ HIV/ AIDS ☐ NONE
OTHER:	

SURGERIES		
YEAR	REASON	HOSPITAL

MEDICATION LIST		
NAME THE DRUG AND DOSAGE:		

GOPAL GRANDHIGE, MD 1315 S. HOWARD AVE. TAMPA FL 33606
INFO@TAMPAREFLUX.COM P 813 922 2920 F 813 742 0711

Pharmacy Name:	
Address:	Phone:

Allergies	
Name the Drug	Reaction You Had

Social history					
Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Alcohol	☐ None	☐ Occasionally	☐ Moderated	☐ Heavy	☐ Recently Quit
Tobacco	☐ Current every day smoker	☐ Current someday Smoker	☐ Former Smoker	☐ Never Smoker	
	Notes:				
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
Marital Status	☐ Single	☐ Married	☐ Separated	☐ Divorced	☐ Widowed	☐ Partnered

Family history			
Diagnosis	Yes	No	Relationship (Specify Maternal aunt, cousin etc)
Diabetes			
High Blood Pressure			
Heart Attack			
Cancer Type:			
Kidney Disease			
Alcoholism/ Chemical Dependency			
Tuberculosis			

Review Of Systems

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

General Health:
- ☐ Appetite Loss
- ☐ Chills
- ☐ Feeling well
- ☐ Fever
- ☐ Night Sweats
- ☐ Obesity
- ☐ Weight Gain___lbs
- ☐ Weight Loss___lbs

Respiratory:
- ☐ Bloody Sputum
- ☐ Cough
- ☐ Difficulty Breathing
- ☐ Difficulty breathing or exertion
- ☐ Sputum Production
- ☐ Wheezing

Gastrointestinal:
- ☐ Abdominal Mass
- ☐ Abdominal Pain
- ☐ Abdominal Swelling
- ☐ Bloating
- ☐ Bloody Stool
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Food Intolerance
- ☐ Heartburn
- ☐ Indigestion
- ☐ Jaundice
- ☐ Laxative Use
- ☐ Nausea
- ☐ Painful Swallowing
- ☐ Pain with Bowel Movement
- ☐ Rectal Bleeding
- ☐ Vomiting
- ☐ Vomiting blood

Breast (Female):
- ☐ Breast Mass
- ☐ Breast Pain
- ☐ Breast Swelling
- ☐ Nipple Discharge
- ☐ Nipple Pain
- ☐ Recent Breast Size Change
- ☐ Skin Changes

Male Genitourinary:
- ☐ Blood in Urine
- ☐ Change in bladder habits
- ☐ Change in urinary stream
- ☐ Incontinence
- ☐ Painful Urination
- ☐ Testicular Pain

Cardiovascular:
- ☐ Abnormal Blood Pressure
- ☐ Chest Pain
- ☐ Edema
- ☐ Heart Stent
- ☐ Hypertension
- ☐ Irregular Heartbeat
- ☐ Palpitations

Musculoskeletal:
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Muscle Pain
- ☐ Muscle Weakness

Female Genitourinary:
- ☐ Blood in Urine
- ☐ Change in bladder habits
- ☐ Change in urinary stream
- ☐ Incontinence
- ☐ Painful Intercourse
- ☐ Painful urination
- ☐ Pelvic Pain

Neck:
- ☐ Neck Pain
- ☐ Neck Mass

Hematology:
- ☐ Abnormal Bleeding
- ☐ Anemia
- ☐ Easy Bruising
- ☐ Enlarged lymph nodes

Neurological:
- ☐ Dizziness
- ☐ Headaches
- ☐ Numbness
- ☐ Seizures
- ☐ Tremor

Other:

MEDICATION HISTORY CONSENT FORM

I, _____, hereby authorize the office of Gopal Grandhige MD to E-Prescribe medications as well as view my medication history.

This authorization will last indefinitely unless this office is notified in writing about any changes.

I certify that the information given here is true and correct to the best of my knowledge. I will also notify you if any changes in my status or in the above information.

Patient Signature: