

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:		

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	☐ OCCASIONAL LY	☐ MODERATED	☐ HEAVY	☐ RECENTLY QUIT
TOBACCO	DO YOU CURRENTLY SMOKE?			YES	NO
	NOTES:				
DRUGS	DO YOU CURRENTLY USE RECREATIONAL OR STREET DRUGS?				☐ YES ☐ NO
	HAVE YOU EVER GIVEN YOURSELF STREET DRUGS WITH A NEEDLE?				☐ YES ☐ NO
ARE YOU AT RISK OF FALLING?					☐ YES ☐ NO
MARITAL STATUS	☐ SINGL E	☐ 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	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
RESPIRATORY: ☐ BLOODY SPUTUM ☐ COUGH ☐ DIFFICULTY BREATHING ☐ DIFFICULTY BREATHING OR EXERTION ☐ SPUTUM PRODUCTION ☐ WHEEZING	MUSCULOSKELETAL: ☐ BACK PAIN ☐ JOINT PAIN ☐ JOINT STIFFNESS ☐ MUSCLE PAIN ☐ MUSCLE WEAKNESS	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	HEMATOLOGY: ☐ ABNORMAL BLEEDING ☐ ANEMIA ☐ EASY BRUISING ☐ ENLARGED LYMPH NODES	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	NEUROLOGICAL: ☐ DIZZINESS ☐ HEADACHES ☐ NUMBNESS ☐ SEIZURES ☐ TREMOR	

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: