

PATIENT HISTORY

NAME: <u>Sachin K C</u> Birthdate: 08/09/1998	
Age: 21 Sex: Male	
Describe briefly your past symptoms: Very low Vitamin B12	
Please list the names of other practitioners you have seen for this problem:	
Past medication History (include where, when, & for what reason):	<p>Bapuji Hospital, Davangere , 23/08/2016, severe headache and vomiting.</p> <p>KIMS Hospital, Hubali, 20/10/2018, headache.</p> <p>Kasturba Hospital Manipal, 13/01/2019, low vitB12.</p>

CURRENT MEDICATIONS		
Drug allergies: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes To what?		
Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:		
Name of drug	Dose (include strength & number of pills per day)	How long have you been taking this?
1. Neurozide Forty	1-0-0	from 6 months
2. Ecosprin 75 mg	0-0-1	from 4 months
3. Ivoral Forte	Weekly once	from 4 months
4.		
5.		

PAST MEDICAL HISTORY

Do you now or have you ever had:

- | | | |
|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Crohn's disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Pulmonary embolism | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Asthma | <input checked="" type="checkbox"/> Jaundice |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Cancer (type) _____ | <input type="checkbox"/> Stroke | <input type="checkbox"/> Stomach or peptic ulcer |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Kidney stones | |

Other medical conditions (please list):

PERSONAL HISTORY

Were there problems with your birth? (specify)- NO

Where were you born & raised?

In Davangere

What is your highest education? ☐ High school ☐ Some college ☐ College graduate ☒ Advanced degreeMarital status: ☒ Never married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered/significant other

What is your current or past occupation?

Are you currently working? : ☐ Yes ☒ No Hours/week _____ If not, are you ☐ retired ☐ disabled ☐ sick leave?Do you receive disability or SSI? ☐ Yes ☒ No If yes, for what disability & how long? _____

Have you ever had legal problems? (specify)-NO

Religion:

Hindu

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age (s)	Health	Age(s) at death	Cause
Father	62	Good	-	-
Mother	58	Good	-	-
Siblings				
Children				

DRUG CATEGORY (circle each substance used)	Do you currently use this?
ALCOHOL	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
SMOKE	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
ANY OTHER:	--