PATIENT HISTORY

NAME: Pramod D P Birthdate: 21/05/1997

Age: 20 Sex: Male

Describe briefly your past symptoms:
Weakness, Stomach pain, Loss of appetite.

Please list the names of other practitioners you have seen for this problem: NO

Past medication History (include where, when, & for what reason):
Sumukha Speciality Hospital(SSH), Sagara, 07/06/2015

CURRENT MEDICATIONS

Drug allergies: ☑ No ❑ 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.		
2.		

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type) _____
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ☑ Typhoid
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

Other medical conditions (please list):

PERSONAL HISTORY

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

Where were your born & raised?- Sagara

What is your highest education? ❑High school ❑Some college ❑College graduate ☑Advanced degree

Marital status: ☑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partnered/significant other

What is your current or past occupation? -NO

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	**58**	**Good**	**-**	**-**
Mother	**52**	**Good**	**-**	**-**
Siblings				
Children	**-**	**-**	**-**	**-**

DRUG CATEGORY (circle each substance used)	Do you currently use this?
ALCOHOL	❑ Yes ☑ No
SMOKE	❑ Yes ☑ No
ANY OTHER:	-