Amba R. Krishnan, M.D.

Patient History Form

Please Print Clearly

Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Home Phone: (___) _____

Occupation: _____ Insurance: _____

Family History

If any blood relative has suffered any of the following – please check the appropriate box and indicate which relative.

- ☐ Heart Attack _____
- ☐ Stroke _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Epilepsy _____
- ☐ Lung Disease _____
- ☐ Arthritis _____
- ☐ Glaucoma _____
- ☐ Hypertension _____
- ☐ Allergies _____

Hospital Admissions

Year	Illness or Operation	Year	Illness or Operation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medications

List the medications you are currently taking

_____

_____

_____

_____

Allergies

List allergies to medicines

_____

_____

_____

_____

Immunizations

If you have received any of the following shots, please check the appropriate box and indicate the approximate date, if known.

- ☐ Small Pox _____
- ☐ Typhoid _____
- ☐ Measles _____
- ☐ Flu _____
- ☐ Mumps _____
- ☐ Rubella _____
- ☐ Diptheria _____
- ☐ Pertussis _____
- ☐ Polio _____
- ☐ Tetanus _____

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Medical History

Check the appropriate answers below. Do not skip any questions.

Yes	No		Yes	No		Yes	No	
____	____	Loss of hearing	____	____	Dizzy spells	____	____	Hemorrhoids
____	____	Ringing in ears	____	____	Hypertension	____	____	Blood in urine
____	____	Ear infections	____	____	Heart murmur	____	____	Frequent urination
____	____	Poor vision	____	____	Palpatations	____	____	Hernia
____	____	Double Vision	____	____	Irregular pulse	____	____	Gall bladder disease
____	____	Eye pain	____	____	Swollen ankles	____	____	Kidney disease
____	____	Eye infections	____	____	Fainting spells	____	____	Sudden weight loss
____	____	Nose bleeds	____	____	Chest pain	____	____	Fatigue
____	____	Sinus trouble	____	____	Numb arm or leg	____	____	Anemia
____	____	Sore throat	____	____	Loss of appetite	____	____	Cancer
____	____	Allergies	____	____	Indigestion	____	____	Diabetes
____	____	Hoarseness	____	____	Stomach ulcers	____	____	Stroke
____	____	Pneumonia	____	____	Diarrhea	____	____	Convulsions
____	____	Bronchitis	____	____	Constipation	____	____	Broken bones
____	____	Asthma	____	____	Bloody stools	____	____	Headaches
____	____	Thyroid disease	____	____	Nervousness	____	____	Chicken Pox
____	____	Back pain	____	____	Depression	____	____	Measles
____	____	Rashes	____	____	Moodiness	____	____	Polio
____	____	Insomnia	____	____	Phobias	____	____	Mumps
____	____	Memory loss	____	____	Mental Illness	____	____	Tuberculosis

Women

Check the appropriate answers below. Do not skip any questions.

Age you started having periods: _____ Date of last period: _____

Flow: Heavy _____ Moderate _____ Light_____

Days of flow: _____Length of cycle: _____

Do you have pain or cramps during your period? _____

Number of pregnancies: _____ Are you a nursing mother? _____

Number of live births: _____

Number of miscarriages: _____

Birth control method: _____

My main health problems are:

1. _____
2. _____
3. _____

If you have any questions or concerns about this form, or any medical or related information not disclosed, please discuss it with the doctor.

If any of the information contained on this form should change, please inform the doctor.

Name: _____ Date: _____

(Signature)