

**Triangle Doctor  
Dr. Himanshu P. Parikh  
Patient History**

Date \_\_\_\_\_

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Occupation/Employment \_\_\_\_\_ Highest level of education \_\_\_\_\_

Reason for visit \_\_\_\_\_

HOSPITALIZATIONS			
If you have been in the hospital overnight, starting with the most recent, state the year, illness/operation.			
YEAR	ILLNESS/OPERATION	YEAR	ILLNESS/OPERATION

PAST MEDICAL and FAMILY HISTORY					
Check if you or any blood relative has any of the following conditions.					
	SELF	RELATION		SELF	RELATION
Allergy/Asthma			High Cholesterol		
Alcohol/Drug Abuse			Liver Disease		
Anemia			Lung Disease		
Anxiety/Depression			Mental Illness		
Arthritis			Obesity		
Blood Disorder			Osteoporosis		
Cancer			Stomach/Intestinal		
Childhood Disease			Seizure		
Diabetes			Stroke		
ENT Disorder			Thyroid Disease		
Headache			Ulcer		
Heart Attack			Urological/Bladder		
Heartburn/Reflux			Weight Gain/Weight Loss		
Heart Disease			Other		
High Blood Pressure					

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING		
MEDICATION/DOSE/TIMES	MEDICATION/DOSE/TIMES	MEDICATION/DOSE/TIMES

DO YOU NOW OR HAVE YOU EVER CONSUMED?				
Cigarettes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pack/Day	# Years
Alcohol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Drinks/Wk	
Coffee/Tea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cups/Day	
Street Drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Type	
Exercise	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Min/Day	Times/Week

DRUG ALLERGIES	
DRUG	REACTION

THE LAST TIME YOU HAD A (YEAR)			
Flu Vaccine		Tetanus Shot	
Hepatitis Vaccine		Pneumonia Shot	
T.B. Test		Rectal Exam	
Stool Blood Test		Eye Exam	
Dental Exam		Colonoscopy	
Cholesterol Test			

FOR WOMEN ONLY			
Date of Last Period			
Birth Control	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Type			
Number of Pregnancies			
Number of Births			
Number of Abortions			
Number of Miscarriages			
YEAR OF LAST			
Pap Test	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	
Breast Exam	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	
Mammogram	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal	

Date of last complete physical: \_\_\_\_\_

Do you have any other problems for which you have been seeing a doctor on a regular basis? Please list them. \_\_\_\_\_

Are you having any symptoms you would like to discuss? Please list them. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Chart # \_\_\_\_\_