Rajesh K. Sethi M.D., PLC

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Patient History – Page 1

Family Physician _____ **Referring Physician** _____ **Today's Date** _____

Patient Name: Last _____ First _____ MI ____ Age _____

Height: _____ **Weight**: _____ **Are you:** Right Handed □ / Left Handed □

Medications (List ALL, including over-the-counter drugs)

Medication	Dose per pill	Number of pills per day

Allergies to Medications

Chief Complaint: What is the reason for this consultation?

SYSTEM REVIEW: Please check/circle any you have ever had or are now being treated for

Neurologic					
Headache □	Neck Pain □	Back Pain □	Arm/Leg pain □	Numbness/Tingling □	Muscle Weakness □
Fatigue □	Blackout □	Seizure □	Dizziness □	Balance Problems □	Memory Problems □
Stroke □	Tremor □	Vision loss □	Hearing loss □	Ringing in Ears □	Loss of Smell □
Hallucinations □	Incontinence □	Trouble sleeping □	Other □		
Emotional	Anxiety □	Depression □	Stress □	Alcohol/Drug Dependency □	Other □
Cardiac	Angina □	Heart attack □	Heart Murmur □	Irregular Rhythm □	High Blood pressure □
Respiratory	Emphysema □	Bronchitis / COPD □	Asthma □	Sarcoidosis □	Tuberculosis □
Abdominal	Peptic Ulcer □	Hiatal hernia / GERD □	Indigestion □	Constipation / Diarrhea □	Other □
Urinary	Bladder problems □	Prostate Problems □	Impotence □	Frequent Urination □	Other □
Oncology	Cancer □ Type _____	Date: _____	Chemotherapy □	Radiation □	Weight Loss □
Hematology	Anemia □	Bleeding problems □	Blood clots □	Low White count /Platelet □	Other □
Skin /ID	Tick Bites □	Lyme's disease □	Rash □	Fever □	Other □
Rheumatogic	Joint pains □	Arthritis □	Lupus □	Rheumatoid disease □	Other □
Endocrinology	Diabetes □	Thyroid disease □	Adrenal problem □	Pituitary □	Other □
Eye	Glaucoma □	Macular Degeneration □	Blind – One □/Both □	Cataract □	Eye Injury □
ENT	Sinusitis □	Ear Pain □	Ear discharge □	Other □	

List serious injuries (broken bones, accidents, etc)

List previous surgeries

List hospitalizations (other than for surgery)

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Patient History – Page 2

Social/Personal History (Please check or circle)

Marital Status Single □ Married □ Widowed □ Divorced □ Separated □

Do you have Children Yes / No How Many _____

Are you working Yes □ / No □ Occupation _____ Retired □ / Disabled □ / Student □ / Homemaker □

Race: White □ / Black □ / Korean □ / Filipino □ / Other _____

Ethnicity: Hispanic □ / Not Hispanic or Latino □ / Other _____

Preferred Language: English / Spanish □ / Other _____

Do you use Alcohol Yes / No How much _____ How long _____

Do you use Tobacco Yes / No How much _____ How long _____

Family History (Please check or circle)

Parents Age: **If living**- Mother _____ Father _____ / Medical Illness – Mother _____ / Father _____

Parents Age at Death – Mother _____ Father ____ / Cause of death if known – Mother _____ Father _____

Check/circle any illness which have occurred in blood relatives

Migraine □	Epilepsy □	Dementia □	Alzheimer's disease □	Stroke □	Tremor □
Diabetes □	High Blood Pressure □		Heart disease □	Depression □	Cancer □
Anemia □	Bleeding tendency □		Arthritis □	Other_____	

Please list the tests you have had for your current problem (Please check or circle)

CT Scan/ MRI Scan – Head/Neck/Back: □ Location if known: _____

EMG: □ / EEG: □ / Neuropsychological testing: □

Carotid Doppler □ / Echocardiogram □

Spinal tap: □ / Myelogram: □

Blood Tests: □ / Approximate date of last tests: _____ / Location of blood tests: _____