

# 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

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**Chief Complaint:** What is the reason for this consultation?

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

#### Neurologic

- |   |                                       |   |                                       |  |  |
|---|---------------------------------------|---|---------------------------------------|--|--|
| Headache <input type="checkbox"/>       | Neck Pain <input type="checkbox"/>    | Back Pain <input type="checkbox"/>        | Arm/Leg pain <input type="checkbox"/> | Numbness/Tingling <input type="checkbox"/> | Muscle Weakness <input type="checkbox"/> |
| Fatigue <input type="checkbox"/>        | Blackout <input type="checkbox"/>     | Seizure <input type="checkbox"/>          | Dizziness <input type="checkbox"/>    | Balance Problems <input type="checkbox"/>  | Memory Problems <input type="checkbox"/> |
| Stroke <input type="checkbox"/>         | Tremor <input type="checkbox"/>       | Vision loss <input type="checkbox"/>      | Hearing loss <input type="checkbox"/> | Ringing in Ears <input type="checkbox"/>   | Loss of Smell <input type="checkbox"/>   |
| Hallucinations <input type="checkbox"/> | Incontinence <input type="checkbox"/> | Trouble sleeping <input type="checkbox"/> | Other <input type="checkbox"/>        |  |  |

**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

**Rheumatologic** 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)**

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**List previous surgeries**

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**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: \_\_\_\_\_