Sweetwater Pulmonary Associates

Sandip Desai, M.D.

GENERAL MEDICAL INFORMATION

Name: ___________________________ DOB: _______________________

Reason for today's visit:

____

____

____

Another physician currently treating you:

____

Previous surgeries/hospitalizations:

____

____

Do you now or have you ever smoked? ______ How many per day? ______ For how long? ______

When did you quit? ______

Do you drink alcohol? Yes ______ No ______

How often? Once a week ______ Twice a Week ______ Three or more x week ______

Do you regularly drink coffee? ______ How many cups per day? ______

FEMALE: Are you pregnant, planning on become pregnant or nursing a child? ______________

PERSONAL MEDICAL HISTORY

Do you have or have you ever had any of the following? (Check all the apply)

___ Anxiety
___ Arthritis
___ Asthma
___ Blood Clots
___ Blood in Stool
___ Bronchitis
___ Cancer/Type?
___ Chest Pain/Tightness
___ COPD
___ Chronic Cough

___ Depression
___ Diabetes
___ Difficulty Hearing
___ Excessive Sleepiness
___ Headaches
___ Heart Attack
___ Hepatitis
___ High Cholesterol
___ Hypertension
___ Hyper/hypo Thyroidism

___ Insomnia
___ kidney disease
___ Memory Loss
___ Pneumonia
___ Reflux
___ Shortness of breath
___ Sleep Apnea
___ Stroke
___ Tuberculosis
___ Ulcers

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FAMYLY HISTORY

Check all that apply	Father	Mother	Father's parents	Mother's Parents
High Blood Pressure	___	___	___	___
Epilepsy	___	___	___	___
Cancer	___	___	___	___
Eczema/Psoriasis	___	___	___	___
Heart Attack/ Stroke	___	___	___	___
Diabetes	___	___	___	___
Asthma	___	___	___	___
Hay Fever	___	___	___	___

ANY INFORTATION THAT YOU WANT TO LET US KNOW?

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