Dr. BP Rajesh, MD

Patient Information

Patient's Name:_____ **Date of Birth:**_____

Address: _____ **Home Phone:** _____

_____ **Cell Phone:** _____

_____ **Work Phone:** _____

Winter address: _____

Social Security Number: _____ **Sex:** __Male __Female

Marital Status: (circle one) Single Married Widow Divorced Sep.

Spouse Name: _____ **Cell Phone:** _____

If Patient is minor (under 18): **Parents &/or Guardians:** _____

Phone number: _____ _____

Emergency Contact (outside of home): _____

Relationship: _____ **Home Phone:** _____ **Cell Phone:** _____

Primary Insurance: _____ **Policy Holder:** _____

Policy Holder DOB: _____ **Relationship:** _____

Secondary Insurance: _____ **Policy Holder:** _____

Policy Holder DOB: _____ **Relationship:** _____

Tertiary Insurance: _____ **Policy Holder/DOB:** _____

Who referred you to this practice: _____

What is your preferred pharmacy: _____

Dr. BP Rajesh, MD

Patient Information

Due to new federal guidelines and regulations, please answer the following questions:

1) **Patients Race:**
   - __ American Indian/Alaskan Native
   - __ Asian
   - __ Black/African American
   - __ Black Hispanic/ Latino
   - __ Native Hawaiian/ Other Pacific Islands
   - __ White
   - __ White Hispanic/Latino

2) **Patients Language Preference:**

__ English	__Japanese
__ Chinese	__ Korean
__ French	__ Portuguese
__ German	__ Russian
__ Italian	__ Spanish

3) **Tobacco History:**

__ I have never used tobacco products.

__ I am a former tobacco user:

a) Circle tobacco products used:

Cigarettes	Pipe
Cigars	Snuff
Chewing Tobacco	Other _____

b) How many packs per day did you smoke? _____

c) How many years did you smoke? _____

d) What year/age did you quit using tobacco products? _____

__ I am a current tobacco user:

a) Circle tobacco products used:

Cigarettes	Pipe
Cigars	Snuff
Chewing Tobacco	Other _____

b) How many packs per day do you smoke? _____

c) What year/age did you start smoking? _____

Dr BP Rajesh, MD

Health History

Name_____ **DOB** _____ **Todays Date**_____

PERSONAL HISTORY (Patient profile):

1) Is patient able to read and write? YES NO

2) Education: Highest level achieved_____

3) Occupation: _____ Usual hours per day_____ Shift_____

4) Habits:

Do you wear your seat belt? (circle one) Always Sometimes Never

Hours of sleep per day _____

Alcohol consumption per week _____

Recreational Drugs? (Marijuana, Cocaine, Speed, LSD, Heroine, other) Yes No

If yes, what? _____ when? _____

Herbal remedies? _____

5) Hobbies: _____

_____

6) Exercise and recreation: (list activities and indicate how often) _____

_____

7) Do you currently see any other physicians? Yes No

If yes, who? _____

FAMILY HISTORY

	Past & Current Health Problems	Age at Death	Cause
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Mother			
Father			
Siblings			
Children			
Grandchildren			

If not noted above, please circle any of the following which have occurred in any of your family members (alive or deceased): Cancer, high blood pressure, heart attacks, strokes, diabetes, glaucoma, chronic diseases of heart, lung or kidneys, liver, serious mental condition, depression, nervous condition or suicide.

PAST MEDICAL HISTORY

1) Illnesses

Childhood:

Problem	Yes	Problem	Yes
Measles		Scarlet Fever	
Mumps		Rheumatic Fever	
Chicken Pox		Mono	
Polio		TB	
Other (list)			

Adulthood:

Problem	Yes	Problem	Yes
Severe Head Trauma		Chronic Constipation	
Concussion		Food Intolerance	
Seizures/Convulsions		Milk Intolerance	
Chronic Sinusitis		Kidney/Bladder Infection	
Chronic Ear Infections		Kidney Stones	
Pneumonia		Hives	
Asthma/Wheezing		Broken Bones	
Cholesterol		Thyroid Disease	
Heart Murmur		Diabetes	
High Blood Pressure		Ulcers	
Chronic Diarrhea		Cancer	
Depression/Anxiety		Glaucoma/Cataracts	
Heart Attack		Emphysema/Chronic Bronchitis	
Heart Failure		Gout	
Other Heart Problems		Stroke	
Other (list)			

2) Operations

Kind	Year	Hospital	Surgeon	Result

3) Hospitalizations (other than for surgeries)

Year	Hospital	Reason	Physician

Tests

	Year done	Hospital/Physician performed
Colonoscopy		
EGD		
Biopsies		
Other		

(If more room is needed, please write on back of this page, under comments section.)

4) Medications

Name of Med	Strength (mg)	How often	Prescribed by

5) Allergies

To Which Med	Reaction	To Which Med	Reaction

6) Immunizations: Full Series Partial None Don't Know

When was your last Tetanus? _____

When was your last pneumo vaccination? _____

7) Have you ever used narcotic medications? Yes No

If yes, what medications and what for? _____

8) Please list any current conditions you would like to discuss:

9) Additional Comments:

Check if you have experienced any of the below in the past year:

__UNEXPECTED WEIGHT LOSS
__UNEXPECTED WEIGHT GAIN
__MORE THIRSTY LATELY
__TIREDNESS/WEAKNESS
__FEVER/CHILLS
__NIGHT SWEATS
__FEELING HOTTER
__FEELING COLDER
__HOT FLASHES
__SNORING
__APNEA/QUITTING BREATHING

__BLURRED VISION
__DOUBLE VISION
__EYE PAIN OR ITCH
__REDNESS
__CATARACTS
__FLASHING LIGHTS
__EXCESSIVE TEARING
__GLASSES
__LAST EYE CHECK WAS IN
__TEMPORARY BLINDNESS
__COLORED HALO

__HEARING PROBLEMS
__HEARING AIDS
__VERTIGO
__RINGING IN EARS
__EAR PAIN

__RUNNY NOSE
__STUFFINESS
__BLEEDING FROM NOSE
__SINUS TROUBLE

__FREQUENT SORE THROAT
__BLEEDING GUMS
__HOARSENESS
__VOICE CHANGE
__DENTURES
__SORES IN MOUTH
__BAD BREATH

__ANEMIA
__TRANSFUSION
__TRANSFUSION REACTION

__DIFICULTY SWALLOWING
__PAIN WHILE SWALLOWING
__THYROID PROBLEM
__NECK STIFFNESS
__NECK PAIN
__SWOLLEN GLANDS

__COUGH
__PHLEGM
__HEMOPTYSIS
__WHEEZING
__SHORTNESS OF BREATH
__ABNORMAL CHEST XRAY
__POSITIVE TB TEST

__CHEST PAIN
__PALPITATION
__RACING HEART
__IRREGULAR HEART BEATS
__SWELLING OF LEGS
__NEED 2 PILLOWS TO SLEEP
__FEET/HAND COLD/BLUE
__PACEMAKER
__MURMUR
__NEED FOR ANTIBIOTICS BEFORE DENTAL VISIT

__HEARTBURN
__BLOATING
__STOMACH PAINS
__NAUSEA
__VOMITING
__DIARRHEA
__CONSTIPATION
__BLACK STOOLS
__BLOOD IN BM
__HEPATITIS
__PANCREATITIS
__JAUNDICE
__PAIN IN ANUS

__MOLE CHANGE
__MOLE REMOVAL
__SKIN CANCER
__SKIN LUMPS
__EASY BRUISING
__HIVES
__ITCHING
__SKIN RASH

__FREQUENCY
__DYSURIA
__HEMATURIA
__NOCTURIA
__URGENCY
__HESITANCY
__DRIBBLING
__INCONTINENCE
__KIDNEY STONES

__LEG SWELLING
__LEG CRAMPS
__RESTLESS LEGS
__LEG PAINS AFTER WALK
__VERICOSE VEINS
__BLOOD CLOTS IN PAST

__JOINT PAINS
__MUSCLE PAINS
__JOINT STIFFNESS
__BACK ACHE
__SHOOTING PAINS IN LEGS
__NECK PAIN
__HIGH CHOLESTEROL
__HIGH TRIGLYCERIDES
__DIABETES MELLITUS
__POTASSIUM PROBLEMS

__MEMORY PROBLEMS
__HALLUCINATIONS
__DEPRESSION
__ANXIETY
__PANIC ATTACKS
__MEMORY PROBLEMS
__MOOD SWINGS
__CRY OFTEN
__LONELY
__LOSS OF APPETITE
__WORRY A LOT
__TREATMENT OF ABOVE IN PAST

__SEVERE HEADACHES
__FAINTING
__DIZZINESS
__LIGHTHEADEDNESS
__STROKE/PARALYSIS
__MINI STROKE
__TINGLING
__NUMBNESS
__TREMORS
__SPEECH PROBLEMS
__HEAD INJURY

FOR WOMEN:

__ BREAST LUMPS
__ BREAST PAIN
__ BREAST DISCHARGE
__ BREAST BIOPSIES
__ ABNORMAL MAMMOGRAMS
__ BLEEDING FROM NIPPLE
__ IRREGULAR PERIODS
__ SPOTTING
__HEAVY BLEEDING
__ SEVERE CRAMPS
__ VAGINAL DISCHARGE
__ USE OF HORMONES

__ LAST PERIOD
__ NUMBER OF PREGNANCIES
__ ARE YOU PREGNANT NOW
__ TYPE OF CONTRACEPTION
__ IF MENOPAUSE; WHEN?_____
__ HYSTERECTOMY
__ DO YOU DO SELF BREAST EXAMS
__ LOSS OF SEX DRIVE
__ HOT FLASHES
__ VAGINAL DISCHARGE

FOR MEN:

__ DISCHARGE FROM PENIS
__ PROSTATE PROBLEMS
__ DIFFICULTY URINATING
__ PROBLEMS WITH ERECTION
__ UP MORE THAN TWICE A NIGHT TO URINATE
__ SORES ON PENIS

AUTHORIZATION

_____ I hereby authorize any holder of medical information to release any information needed to determine benefits and I hereby irrevocably assign Medicare benefits and/or any other medical benefits to B. Rajesh, M.D. for my medical services rendered.

_____ I understand that I am financially responsible for all charges whether or not covered by my insurance.

_____ I understand it is my responsibility to check with my insurance policy regarding the coverage of any and all lab and radiology testing, as well as referrals to out-of-network facilities and/or specialists.

_____ I hereby attest that all of the provided information is true and accurate to the best of my knowledge.

Patients Name (Printed) _____ DOB _____

Signature- Responsible Party _____ Date _____

~*Patient Portal*~

We are currently in the process of constructing a safe and secure website, accessible through what is called a patient portal, that will allow patients to:

- Receive labs and test results through a secure server.
- Communicate with office staff regarding appointment scheduling and/or non-urgent messages.

This new service is available to our patients free of charge, we just ask that you:

- Do not use the patient portal for critical issues (such as chest pain).
- Please try to keep messages brief and precise to help us better serve you.

Weblink is available on our home page at ***www.DrRajesh.com*** under *Patient Portal.*

Are you interested in receiving your test results through a HIPPA compliant, safe and secure web portal?

___ Not at this time.

___ Yes, I would like to set up an account.

If yes, Please **provide your email address** on the line below. Office staff will work to set up your account as soon as possible. Your updox patient portal account login and password will automatically be sent to you via email.

Email address: _____

Patients Name: _____ DOB _____