Batish Family Medicine

Welcome! We would like to learn more about you ☺

Full Name: ____________________ Date of Birth: ____________

Phone: ____________ Email: ____________________

Local Pharmacy: ________________ Mail Order Pharmacy: ____________

Reason for your visit today: ____________________

Previous/Current Physician(s): ____________________

How did you hear about us?: ____________________

Allergies

____

____

Your Medications:

Medication Name	Dosage	How Often?	30/60/90 day RX?	Refills needed?

Your Medical History:

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis (Type __________)
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Blood Clots/Clotting Disorder
- ☐ Cancer (Type ___________)
- ☐ COPD/Emphysema
- ☐ Coronary Artery Disease/Stents
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes (Type 1 or 2)
- ☐ Enlarged Prostate (BPH)
- ☐ Fibromyalgia
- ☐ GERD/Reflux
- ☐ Headaches/Migraines
- ☐ Heart Attack
- ☐ Heart Disease/Heart Failure
- ☐ Hepatitis/Liver Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Irritable Bowel
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Disease
- ☐ Tuberculosis

- ☐ Women Only:
- ☐ Abnormal PAP Smear

# of Pregnancies: __________
# of Children: ____________
Last Menstrual Period:
____

Any other medical problems not listed above?

____

____

Preventative Screening	Date	Results
Colonoscopy/Cologuard		
Mammogram (Women Only)		
PAP Smear (Women Only)		
DEXA (Bone Density)		

Surgeries (example: hysterectomy)	Date (year)

Health Habits and Personal Safety

What is your occupation? ____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Life Partner

Who do you live with? ____

What are your hobbies/interests? ____

Do you exercise regularly? ☐ Yes ☐ No If yes, please describe: ______________________________

Tobacco Use: ☐ Current User ☐ Never User ☐ Former User

Type Used: ______________________ Amount per day: _____________ # of Years Used: _______ Quit Year: ________

Alcohol Use: ☐ Current User ☐ Never User ☐ Former User

Type of Alcohol: ____________________________________ Amount per week: ________________________

Drug Use/Substance Abuse: ☐ Never User ☐ Current User ☐ Former User **Type used:** ________________________

Firearms Exposure: Are firearm(s) kept in the household? ☐ Yes ☐ No

If yes, please continue: Are firearms properly secured? ☐ Yes ☐ No Are firearms kept loaded? ☐ Yes ☐ No

Your Family Health History

☐ Please check here if adopted or if no family history available

Biological Family Member	Deceased?	Age	List any known medical problems and age of diagnosis
Mother			
Father			
Sister(s)			
Brother(s)			
Daughter(s)			
Son(s)			