GUPTA MEDICAL SPECIALISTS

NEW PATIENT INFORMATION FORM -*ENDO*

Please print all information. Thank you for your cooperation.

Patient Name: _____

Date of Birth: _____ Social Security #_____

Address: _____

City: _____

State: _____ Zip Code:_____

Phone (home):_____ Work/Cell: _____

Employer: _____

Marital Status: Single Married Divorced Widowed

Email Address: _____

Is it ok to mail correspondence such as reminders and letters to you? ____Yes ____No

Referring Physician or Referral Source:

_____

Primary Care Physician:

_____

Do you want your medical records sent to this practice? ___Yes ___No

Insurance Plan: _____

Group Number: _____ Policy Number: _____

Issue Date: _____

Secondary Insurance Plan: _____

Group Number: _____ Policy Number: _____

Issue Date: _____

Thank you for taking the time to complete our intake forms. Please sign & date (below)

_____ _____

Patient's Signature Today's Date

HISTORY OF PRESENT ILLNESS

1. Age:_____ Male Female
2. What medical problem are you being seen for?

   _____

   _____
3. When were you diagnosed?

   _____

   _____
4. How were you diagnosed?

   _____

   _____
5. What are you being treated with?

   _____

   _____
6. Have you had any imaging (xray, MRI, ultrasound, etc) done for this area?

   _____

   _____

   If so, where and when?

   _____

   _____

Past Medical History:

No Medical History	COPD	Kidney Disease	Seizures
Please circle all that apply	Emphysema	Stroke/CVA	Osteoarthritis
Hypertension	Obstructive Sleep Apnea	Headaches/Migraines	Rheumatoid Arthritis
Congestive Heart Failure	Hepatitis	Anemia	Gout
Abnormal Heart Rhythm	Diabetes Type 1 2	Lupus	Endometriosis
Heart Disease, CAD	Hypothyroidism	Reflux	Cancer (specify type)
Peripheral Vascular Dz	Hyperthyroidism	Irritable Bowel	
Blood Clots /DVT	Enlarged Prostate/BPH	Anxiety	Other _____
High Cholesterol	Osteoporosis	Depression	

Past Surgical History:

No Surgical History	Tonsil	Eye	Hip Replacement
Please circle all that apply	Thyroid	Ear	Knee Surgery
Heart Bypass	Appendix	Prostate	Neck Surgery- Fusion
Heart Pacemaker	Gallbladder	Kidney	Back Surgery-Fusion
Angioplasty Stent	Gastric Bypass	Bladder	Other _____
Brain	Hysterectomy	Hernia	
Lung	C-Section	Shoulder – Rotator Cuff	

Family History:

Relative	***Age/Living***	***Health Problems***
Father		
Mother		
Brother		
Sister		

Allergies (to medications and food)

_____

Medications:

(please include all herbal supplements and/or vitamins)

SOCIAL HISTORY

1. Current work status_____ Occupation: _____

2. Marital Status: Single Married Divorced Widowed

3. Number of Children: _____

4. I live: Alone With: _____ I live in a: House Apartment Nursing Facility

5. Are you a cigarette smoker? No Yes How old were you when you began smoking? _____
   How much do you smoke daily? _____ When did you quit smoking? _____

6. Do you drink any alcoholic beverages: (check one) No Yes
   1 2 3 4 5 6 drinks daily weekly monthly social use only

7. Have you ever had a problem with drug dependence? Yes No

8. Please write any additional information that you feel is important for us to know.

_____

_____

REVIEW OF SYTEMS

Do you currently have any of the following medical symptoms?

General
- o Unexplained weight loss
- o Appetite change
- o Fevers or chills
- o Night sweats
- o Marked fatigue
- o Difficulty sleeping

Eyes
- o Glasses
- o Change in vision
- o Double vision

Ear, Nose, Throat
- o Difficulty swallowing
- o Hoarseness
- o Loss of hearing
- o Ear pain
- o Nosebleeds

Cardiovascular
- o Heart or chest pain
- o Abnormal heartbeat
- o Leg swelling

Respiratory
- o Morning cough
- o Shortness of breath
- o Productive cough or sputum

Digestive
- o Nausea or vomiting
- o Stomach pain or ulcers
- o Heart burn
- o Diarrhea
- o Constipation
- o Uncontrolled loss of stool
- o Blood in stools

Skin
- o Rashes
- o Itchiness
- o Easy bruising

Neurological
- o Seizures
- o Blackouts/fainting
- o Headaches/migraines

Musculoskeletal
- o Joint pains
- o Joint swelling
- o Numbness in feet/hands
- o Muscle weakness

Genitourinary
- o Burning on urination
- o Incontinence
- o Pelvic pain
- o Impotence
- o Abnormal Bleeding

Psychiatric
- o Depression
- o Anxiety
- o Paranoia

Other

_____

_____

_____

_____

_____