

# PRASUNA SAJJA, M.D., P.A.

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## Patient History

Patient Name: Last Name MI First Name Sex: M / F Birth Date:

Reason for today's visit:

**LIST ALL ALLERGIES AND DRUG SENSITIVITIES** **LIST ALL MEDICATIONS TAKEN ON REGULAR BASIS INCLUDING VITAMINS AND HERBAL SUPPLEMENTS (SPECIFY DOSE AND FREQUENCY)**

1)	1)
2)	2)
3)	3)
4)	4)
5)	5)

**LIST ALL PRIOR SURGERIES (SPECIFY DATE / REASON)** **LIST ALL PRIOR HOSPITALIZATIONS (SPECIFY DATE / REASON)**

1)	1)
2)	2)
3)	3)
4)	4)

**LIST ALL IMMUNIZATIONS / HEALTH MAINTENANCE YOU HAVE HAD (SPECIFY DATE)**

Pneumonia Shot: Yes / No	Date of Last:	Last Physical	Date of Last:
Hepatitis B Series / Shot: Yes / No	Date of Last:	Last Blood Work	Date of Last:
Tetanus Shot (in last 10 yrs): Yes / No	Date of Last:	Colonoscopy / Colon screening	Date of Last:
Flu shot: Yes / No	Date of Last:	Prostate exam ( <i>males only</i> )	Date of Last:
PPD (TB) Test: Yes / No	Date of Last:	Last Pap-smear ( <i>females only</i> )	Date of Last:
History of Chicken pox disease: Yes / No	Date of Last:	Last mammogram ( <i>females only</i> )	Date of Last:

**LIST ANY CHRONIC OR RECURRENT ILLNESS (SPECIFY DATE OF ONSET)**

1) Diabetes: Yes / No	Date of Onset:	5) Asthma: Yes / No	Date of Onset:
2) High Blood Pressure: Yes / No	Date of Onset:	6) COPD: Yes / No	Date of Onset:
3) Cholesterol: Yes / No	Date of Onset:	7) Thyroid disease: Yes / No	Date of Onset:
4) Heart Disease: Yes / No	Date of Onset:	8) Other:	Date of Onset:

**CHECK ANY THAT YOU HAVE HAD OR NOW HAVE**

<input type="checkbox"/> AIDS or HIV Disease	<input type="checkbox"/> Headaches (migraine)	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Anemia (i.e. low iron)	<input type="checkbox"/> Hearing Problem	<input type="checkbox"/> Polio
<input type="checkbox"/> Anxiety or Panic Attacks	<input type="checkbox"/> Heart Murmur or Heart Disease	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Arthritis or Gout	<input type="checkbox"/> Hepatitis or Cirrhosis	<input type="checkbox"/> Seizures/Convulsions/Epilepsy
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Herniated/Ruptured Disc	<input type="checkbox"/> Sexually Transmitted Diseases
<input type="checkbox"/> Blood Clots or Bleeding Problems	<input type="checkbox"/> Herpes	<input type="checkbox"/> Gonorrhea
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Hodgkins Disease/Lymphoma/Leukemia	<input type="checkbox"/> Chlamydia
<input type="checkbox"/> Bowel or Colon Disease	<input type="checkbox"/> Irritable Bowel Syndrome	<input type="checkbox"/> Syphilis
<input type="checkbox"/> Breast Lumps	<input type="checkbox"/> Kidney Disease or Nephritis	<input type="checkbox"/> Other
<input type="checkbox"/> Cancer	<input type="checkbox"/> Liver Problems	<input type="checkbox"/> Sickle Cell Disease or Trait
<input type="checkbox"/> Colitis	<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Stroke or mini-stroke
<input type="checkbox"/> Concussion or Head Injury	<input type="checkbox"/> Lupus	<input type="checkbox"/> Tuberculosis (TB) or Positive Test
<input type="checkbox"/> Depression or Suicide	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Ulcer Disease or Gastritis
<input type="checkbox"/> Gall bladder Disease / Gallstone	<input type="checkbox"/> Muscle Disease or Weakness	<input type="checkbox"/> Other _____
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Other _____

**DIET, EXERCISE, AND HABITS:**

Do you follow a special diet? Yes / No	If Yes, specify what type of diet:	
Current Weight:	Desired Weight:	Weight one year ago:
What kind of exercise do you do and how often do you do?		

**TOBACCO USE:**

Do you smoke? Yes / No	If Yes, specify what type:	How long have you been smoking:	How much per day?
Have you quit smoking? Yes / No	If Yes, when?	Do you use other tobacco products? Yes / No	
Are you exposed to smoke? Yes / No			

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## ALCOHOL USE:

Do you drink alcohol? Yes / No      If Yes, specify how much? \_\_\_\_\_ per day / week / month

Has anyone ever expressed concerns about your alcohol use? Yes / No      If Yes, please explain?

## OTHER:

Are you sexually active? Yes / No      Do you / your partner use any type of birth control / protection? Yes / No      If yes type ?

Do you use illicit drugs? Yes / No      If Yes, specify \_\_\_\_\_      Do you use a seatbelt? Yes / No      Do you use sunscreen? Yes / No

## SOCIAL HISTORY

Marital Status:  Minor     Single     Married     Separated     Widowed     Divorced     Partnered for \_\_\_\_\_ Yrs

With whom do you now live with?

Current Job: \_\_\_\_\_      Previous Job: \_\_\_\_\_

Are you exposed to hazardous conditions / substances at work?

## QUESTIONS FOR WOMEN ONLY:

Age Periods Began: \_\_\_\_\_      How often: \_\_\_\_\_

Last menstrual Period: \_\_\_\_\_      PMS (Pre-menstrual Syndrome): Yes / No

History of abnormal Pap smears: Yes / No, If Yes, explain:

History of abnormal Mammogram: Yes / No, If Yes, explain:

Pregnancies: Total # \_\_\_\_\_      Full Term \_\_\_\_\_      Premature \_\_\_\_\_      Miscarriages \_\_\_\_\_      Abortions \_\_\_\_\_  
Tubal Pregnancies \_\_\_\_\_      # of living children \_\_\_\_\_

Any complications during pregnancies?

## FAMILY HEALTH STATUS (if applicable)

Family Member	Age	Health Status (Good / Fair / Poor)
Spouse:		
Son / Daughter:		
Son / Daughter:		
Son / Daughter:		
Son / Daughter:		

## FAMILY ILLNESS HISTORY (HAS ANY BLOOD RELATIVE HAD ANY OF THE FOLLOWING)

Illness	Yes/No	Relationship	Illness	Yes/No	Relationship
Allergies			High Blood Pressure		
Anemia			High Cholesterol		
Asthma			Kidney Disease		
Arthritis			Mental Retardation		
Cancer: Type _____			Stroke		
Cancer: Type _____			Thyroid Disease		
Diabetes			Tuberculosis		
Heart Disease			Other _____		

If the Patient is under 18 years of age, unless the Patient is an emancipated minor, this form must be signed by a parent, guardian, or legal representative who has the authority to act on the minor Patient's behalf. By signing this form for someone else, you as the parent, guardian, or legal representative, warrant that you have the legal authority to act on the Patient's behalf. I hereby certify that all information provided by me in this form is true, complete and accurate.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If signed by someone other than patient, Print your name and state your legal relationship to the patient