DOLORA PAIN MANAGEMENT ASSOCIATES, P.C.

Sayeed Khan, MD

PLEASE COMPLETE ALL QUESTIONS

Today's Date:____/____/_____

Patient History Form

Patient Name:_____ Date of Birth:_____/_____/_____ Sex: Male Female

PCP (PRIMARY DOCTOR):_____ Phone:_____ Fax:_____

Please circle any of the symptoms you have *had* or *now* have:

Review of Systems:

Ears: *Decreased Hearing* Ear Discharge *Earache* Ringing in Ears

Nose &Throat: Mouth Ulcers *Nasal Congestion* Sore Tongue *Nose Bleeds* Sinus Pain *Sore Throat*

Respiratory: *Dyspnea at rest* Pain with Inspiration *Cough* Shortness of Breath *Sleep Apnea* Wheezing

Cardiovascular: *Chest Heaviness* Chest Pain *Chest Tightness* Abnormal Heartbeat *Shortness of Breath* Palpitations

Gastrointestinal: Abdominal Pain *Constipation* Diarrhea *Heartburn* Loss of Appetite *Nausea* Bloody Stool

Genitourinary: Erectile Dysfunction *Genital Sores* Incontinence *Vaginal Discharge* Penile Discharge *Burning Urination*

Integumentary: Dry Rash Mole Change Itchy Lesion

Psychological: Depression Anxious Confused Nervous Stressed Disturbing Thoughts Excessive Worry

Neurological: Headaches Dizziness Fainting Migraines Seizures Numbness Muscular Weakness Restless Legs

Past History:

Please List Any Surgeries:_____

_____

Please circle the following if you have been treated for them:

High Blood Pressure	Asthma	Emphysema
Heart Murmur	Ulcer	Anemia
Diabetes	Colitis	Thyroid Disease
Epilepsy	HIV/AIDS	Rheumatoid Arthritis
Cancer	Herpes	Hepatitis

Allergies:_____

Medications (Directions and Dosages):_____ _____

_____ _____ _____

_____ _____ _____

Marital Status: Please circle one: Married Divorced Separated Single

Tobacco Usage: YES or NO If yes, how much?:_____

Alcohol Consumption: YES or NO If yes, how often?:_____

Street Drugs: YES or NO If yes, please explain?:_____

Patient Signature:_____ Date:____/_____/_____