

**FARRUKH IMTIAZ, M.D.**

**MEDICAL HISTORY**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Birthplace: \_\_\_\_\_ Hobbies: \_\_\_\_\_

**HABITS**

Do you smoke? No \_\_\_ Yes \_\_\_ How long? \_\_\_\_\_ How much? \_\_\_\_\_

Do you drink alcoholic beverages? No \_\_\_ Yes \_\_\_ How long? \_\_\_\_\_ Frequency? \_\_\_\_\_

Do you take recreational drugs? No \_\_\_ Yes \_\_\_ What? \_\_\_\_\_ Frequency? \_\_\_\_\_

**PAST MEDICAL HISTORY (Check all that apply)**

<b>Ailment</b>	<b>Self</b>	<b>Family</b>	<b>Ailment</b>	<b>Self</b>	<b>Family</b>
Heart Trouble	___	___	Cancer	___	___
Diabetes	___	___	Emphysema	___	___
Liver Disease	___	___	Stroke	___	___
Multiple Sclerosis	___	___	Thyroid Trouble	___	___
Hypertension	___	___	HIV/AIDS	___	___
Epilepsy/Seizures	___	___	Anemia	___	___
Kidney Trouble	___	___	Phlebitis/Varicose Veins	___	___
Asthma/Allergies	___	___	Gall Bladder	___	___
Bowel Disorders	___	___	Glaucoma/Cataracts	___	___

When was your last Tetanus Shot? \_\_\_\_\_ Are you interested in yearly flu shots? \_\_\_\_\_  
 Have you had pneumonia? \_\_\_\_\_

**SURGICAL PROCEDURES**

**DATES**

_____	_____
_____	_____
_____	_____

**MEDICATION ALLERGIES**

**REACTIONS**

_____	_____
_____	_____

**Do you suffer from any of the following?**

**(Check all that apply)**

Dizziness/Weakness___	Insomnia___	Weight loss/gain	___
Anxiety___	Eye Trouble___	Shortness of Breath	___
Hemorrhoids___	Coughing___	Headaches	___
Frequent Indigestion___	Arthritis___	Blood in Stool	___
Chronic Back Pain___	Neck Pain___	Chest Pain	___
Abdominal Pain___	STD___	Coughing Blood	___
Frequent Indigestion___	Diarrhea___	Constipation	___

Any additional \_\_\_\_\_

**CURRENT MEDICATION**

**DOSAGE**

**FREQUENCY**

_____	_____	_____
_____	_____	_____
_____	_____	_____

**Do you have any concerns about your health which are not mentioned above?**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_