DVINDER KAUR, MD
PRIME MEDICAL ASSOCIATES LLC
HEALTH HISTORY

Patient Name: _____ Today's date_____

Date of Birth:_____ Age:_____ Gender: Male / Female Height_____ Weight_____

Reason for visit: _____

_____

Are you **ALLERGIC** to anything? Yes / No (if yes, please list)_____

_____

Past/Current medical conditions:	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Hospitalizations/Serious Illness/Injuries:		
Year	Hospital	Reason

Have you had any **surgeries or procedures**: Yes / No. If yes, please list procedure and date			
Procedure	Date	Procedure	Date
1.		3.	
2.		4.	

Medications: (include all supplements) □ *no medications*					
Name	Dosage	times/day	Name	Dosage	times/day
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

Health Habits:

Current	Past	Behavior	Description and Frequency
□	□	Exercise	
□	□	Tobacco Use	
□	□	Alcohol Use	
□	□	Caffiene	
□	□	Drug use	
□	□	High Risk Sexual Behavior	

Sexual Orientation: *(circle):* Heterosexual Homosexual Bisexual Other:_____

Have you ever had a blood transfusion? Yes/ No If yes, approximate date:_____

DVINDER KAUR, MD
PRIME MEDICAL ASSOCIATES LLC
HEALTH HISTORY

Patient Name: _____Date of Birth:_____

Family History: How many children do you have?_____

Please fill in health information about your family. Include any relatives who have serious health illnesses, especially cancer or heart disease OR anything that is important for your doctor to know.

Relationship	Age	age of death	Significant Medical Illnesses (if any)
Mother			
Father			
Sister			
Sister			
Brother			
Brother			
Daughter			
Son			

Women's Health:
Are you Pregnant / Nursing?_____ Date of Last Menstrual Period:_____
How many times were you pregnant?_____ Any complications during Pregnancy?_____

What is your **occupation**?		retired	unemployed	disabled
Does your work expose you to:				
Stress: No / Yes	Hazardous Materials: No/Yes *type*_____	Heavy Lifting: Yes/No	Other:	

Preventive care *(when was your last….)*			
Procedure	**Date**	**Immunization**	**Date**
Physical Exam		Tetanus	
Eye Exam		Pneumonia	
PAP Smear		Hepatitis B	
Mammogram		Shingles	
Colonoscopy		Influenza	

Additional Information:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of her staff responsible for any errors or omissions that I may have make in the completion of this form.

Signature:_____Date:_____

If not filled out by patient: Name:_____ Relationship to patient_____