Chandrahas Agarwal, M.D.

PATIENT HISTORY FORM

PLEASE PRINT AND BRING TO YOUR APPOINTMENT **DATE OF APPOINTMENT: _____**

Name: _____Date of Birth: _____ Age: _____ Sex: M / F

Referring Physician: _____ Pharmacy: _____

WHEN DID YOU LAST SEE A PHYSICIAN? DATE: _____ NAME OF PHYSICIAN? _____
REASON YOU ARE BEING SEEN TODAY: _____
DO YOU SMOKE? YES NO HOW MANY PACKS PER DAY? _____ IF YOU QUIT, HOW LONG AGO? _____
DO YOU USE ALCOHOL? YES NO HOW MANY DRINKS PER DAY? _____ IF YOU QUIT, HOW LONG AGO? _____
DO YOU USE ILLICIT DRUGS? YES NO PLEASE LIST _____ FREQUENCY _____
HOW MUCH DO YOU WALK? _____ WHY DO YOU STOP? _____
HOW OFTEN DO YOU EXERCISE? _____ WHAT KIND OF EXERCISE DO YOU DO? _____
_____

HOSPITALIZATIONS/SURGERIES

DATE	HOSPITAL	REASON/SURGERY

CURRENT MEDICATIONS, PRESCRIPTION, OVER THE COUNTER, HERBAL SUPPLEMENTS

MEDICATIONS	DOSAGE	HOW OFTEN TAKEN

Allergies – Drug or food items

DRUG/FOOD/ITEM	TYPE OF REACTION

Occupation: _____

HEALTH HISTORY - CONDITION	**CHECK BOX IF HAVE OR HAD**	**DATE**
HEART ATTACK		
STROKE		
LOSS OF CONSCIOUSNESS		
DIABETES		
HIGH CHOLESTEROL		
HIGH BLOOD PRESSURE/HYPERTENSION		

♥ 8287 White Oak Avenue, Rancho Cucamonga, CA 91730 Phone: (909) 476-0808 Fax: (909) 476-0811

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CONDITION;	CHECK BOX IF HAVE OR HAD	DATE
IRREGULAR HEART BEAT OR MURMUR		
SWELLING OF FEET/ANKLES		
SHORTNESS OF BREATH		
LIST THE NUMBER OF PILLOWS DO YOU USE TO SLEEP		
DO YOU GET UP AT NIGHT BECAUSE YOU CANNOT BREATHE		
CANCER		
CHEST PAIN DURING WALKING OR PHYSICAL ACTIVITY		
SEIZURES		
MIGRAINE HEADACHES		
STOMACH ULCER		
ASTHMA		
CHANGE IN WEIGHT		
CHANGE IN APPETITE		

FAMILY HISTORY

FATHER: AGE: _____ MEDICAL HISTORY: _____

_____

MOTHER: AGE: _____ MEDICAL HISTORY: _____

_____

BROTHER: AGE: _____ MEDICAL HISTORY: _____

_____

SISTER: AGE: _____ MEDICAL HISTORY: _____

_____

Patient Signature: _____ Date: _____

Please print name: _____

NOTE: The above information is a confidential record and will not be released without your consent.

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