BIRJIS K. ALAM, MD PA

Patient Name: _____ DOB: _____ AGE: _____ SEX: _____ DATE: _____

Address: _____

Phone # (H): _____ (W): _____ (Cell): _____

Race: _____ Ethnicity: _____ Language: _____ Email Address: _____

Social Security #: _____ Spouse's Name: _____ Work Phone: _____

Emergency Contact: _____ Relationship: _____ Ph #: _____

Whom may we thank for referring you to us: _____ Home:_____

Allergies/Adverse Reactions? O Yes O No If yes, please list:_____
_____

Please review the following questions and darken/check in the circles of the symptoms that apply to you only:

CONSTITUTIONAL

weight gain	O Yes	O No
loss of appetite	O Yes	O No
fever	O Yes	O No
weakness	O Yes	O No
weight loss	O Yes	O No
fatigue	O Yes	O No
night sweats	O Yes	O No

HEENT

Change in vision	O Yes	O No
hearing loss	O Yes	O No
diminished vision	O Yes	O No
pain in eyes or ears	O Yes	O No
discharge from ears	O Yes	O No
eye irritation or redness	O Yes	O No
sore throat	O Yes	O No
nose bleed	O Yes	O No

ENT/RESPIRATORY

cough	O Yes	O No
pain with breathing	O Yes	O No
shortness of breath	O Yes	O No
coughing up blood	O Yes	O No

CARDIOLOGY

chest pain	O Yes	O No
palpitations	O Yes	O No
shortness of breath	O Yes	O No
leg cramps	O Yes	O No
pain in legs while walking	O Yes	O No
irregular heartbeat	O Yes	O No

DERMATOLOGY

rash	O Yes	O No
lumps	O Yes	O No
hives	O Yes	O No
skin cancer	O Yes	O No
laceration	O Yes	O No

GASTROENTEROLOGY

diarrhea	O Yes	O No
vomiting	O Yes	O No
constipation	O Yes	O No
nausea	O Yes	O No
difficulty swallowing	O Yes	O No
abdominal pain	O Yes	O No
heartburn	O Yes	O No
hemorrhoids	O Yes	O No
indigestion	O Yes	O No
frequent bloating	O Yes	O No
vomiting blood	O Yes	O No
rectal bleeding	O Yes	O No

MUSCULOSKELETAL

joint pain	O Yes	O No
joint swelling	O Yes	O No
osteoporosis treatment	O Yes	O No
back pain	O Yes	O No
muscle pain or weakness	O Yes	O No
tingling/numbness	O Yes	O No

UROLOGY

difficulty urinating	O Yes	O No
blood in urine	O Yes	O No
frequent urination	O Yes	O No
urinary incontinence	O Yes	O No
pain with urination	O Yes	O No

PSYCHOLOGY

depression	O Yes	O No
sleep disturbances	O Yes	O No
angry	O Yes	O No
sad	O Yes	O No
happy	O Yes	O No
other	O Yes	O No

ENDOCRINOLOGY

cold intolerance O Yes O No
heat intolerance O Yes O No
diabetes O Yes O No
excessive thirst O Yes O No
hot flashes O Yes O No
urinating frequently O Yes O No

HEMATOLOGY/LYMPH

swollen glands O Yes O No
varicose veins O Yes O No
easy bleeding O Yes O No
anemia O Yes O No
past transfusion O Yes O No

NEUROLOGY

headache O Yes O No
tingling/numbness O Yes O No
seizures O Yes O No
memory loss O Yes O No
dizziness O Yes O No
loss of strength in specific body area O Yes O No
loss of sensation ins specific body area O Yes O No
Migraines O Yes O No
burning pain in feet O Yes O No
trouble with balance O Yes O No
trouble with coordination O Yes O No
loss of consciousness O Yes O No
confusion O Yes O No

PAST MEDICAL HISTORY

hypertension O Yes O No
diabetes O Yes O No
hypercholesterolemia O Yes O No
atrial fibrillation O Yes O No
coronary artery disease O Yes O No
valve replacement O Yes O No
hepatitis C O Yes O No
hepatitis B O Yes O No
treated cancer (not current) O Yes O No
Blood Clot in extremities or lungs O Yes O No

SURGICAL HISTORY

Appendectomy O Yes O No
Hysterectomy O Yes O No
Coronary Bypass O Yes O No
Carotid endarterctomy O Yes O No

SOCIAL HISTORY

Occup. exposure: O yes O no O asbestos O chemicals O second hand smoke
Drug Abuse: O Yes O No

FAMILY HISTORY:

Do you have any first degree family member (mother, father, brother, etc) with?

O hypertension O diabetes O hypercholesterolemia O blood clot in extremities or lungs O cancer

Please let us know the reason(s) for your visit today? If you are in pain, please describe location, severity and the onset of the pain:

Is your visit due to an injury? O Yes O No

If yes: O Work O Auto O Other

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

X _____ _____
Signature Date

For MA Use only

VITAL SIGNS: STANDING BP: L _____/_____ OR R _____/_____ HT _____ WT _____ BMI _____
SITTING BP: L _____/_____ AND R _____/_____ TEMP _____ PULSE _____ TAKEN BY: _____

Miscellaneous Medical Notes: _____
