



DHAMY SIVAMOCHAN, MD

PHONE: (812) 752-4001

WEB: WWW.FMA-PC.COM

Health History

Last name: _____ First name: _____ DOB: _____

Reason for your visit today:

Personal Medical History

Constitutional e.g., fever, heat stroke, weight loss, weight gain, unusually tired, etc.

Yes No

Comments: _____

Ear/Nose/Throat e.g., hard of hearing, stuffy nose, earache, cough, dry mouth, etc.

Yes No

Comments: _____

Heart (Cardiovascular) e.g., high blood pressure, racing pulse, chest pain, unable to exercise, etc.

Yes No

Comments: _____

Lungs (Respiratory) e.g., congestion, wheezing, shortness of breath, productive or bloody cough, asthma, etc.

Yes No

Comments: _____

Digestion (Gastrointestinal) e.g., stomach upset, diarrhea, constipation, hernia, ulcers, pain/cramps, acid reflux, etc.

Yes No

Comments: _____

Muscles and bones (Musculoskeletal) e.g., muscle pain/cramps, joint pain swelling, stiffness, etc.

Yes No

Comments: _____

Urological e.g., painful or frequent urination, burning, impotence, incontinence, infections, etc.

Yes No

Comments: _____

Gynecological e.g., pregnancies, menstrual problems, ovarian and uterine conditions, etc.

Yes No

Comments: _____

Breast e.g., cysts, fibroids, pain, numbness, lumps, etc.

Yes No

Comments: _____

Neurological *e.g., numbness, weakness, headaches, paralysis, seizures, tremors, tingling, etc.*

Yes No

Comments: _____

Psychiatric *e.g., depression, anxiety, mood swings, insomnia, hallucinations, disorientation, etc.*

Yes No

Comments: _____

Blood/Lymphatic *e.g., high cholesterol, anemia, blood disorders, leukemia, prolonged bleeding, etc.*

Yes No

Comments: _____

Skin *e.g., itching, rash, infection, ulcer, tumors or growths, warts, excessive dryness, etc.*

Yes No

Comments: _____

Cancer

Yes No

Comments: _____

Allergic/Immunologic *e.g., recurrent infections, hay fever, food allergy, drug sensitivity, hives, redness, itching, etc*

Yes No

Comments: _____

Hormones (Endocrine) *e.g., diabetes, thyroid problems, fatigue, hair loss, hot/cold intolerance, etc.*

Yes No

Comments: _____

IF DIABETIC:

Doctor and contact information: _____

Year of diagnosis: _____ **Result/Time of last blood sugar:** _____

Last hemoglobin A1C: _____ **Treatments:** _____

Major illnesses/Hospitalizations

Yes No

Comments: _____

Surgeries

Yes No

Comments: _____

Family History
(Parents, Siblings, or Grandparents only)

[Insert specific history relevant to your specialty]	
Systemic Disease	
<input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> Heart disease	<input type="checkbox"/> Hypertension <input type="checkbox"/> Arthritis <input type="checkbox"/> Other: _____

PERSONAL SOCIAL HISTORY

Marital status: _____

Living arrangements: _____

Have you been exposed to venereal disease/sexually transmitted infection?

Yes No

Are you pregnant?

Yes No

Occupation(s): _____

Occupational exposure:

Yes No

Recent travel:

Yes No

Tobacco use

Never Current everyday use Current intermittent use Former use Status unknown Other: _____

Alcohol use

Never Current everyday use Current intermittent use Former use Status unknown Other: _____

Recreational drug use

Never Current everyday use Current intermittent use Former use Status unknown Other: _____

Medications: List ALL medications you are CURRENTLY taking. (Include all herbals, vitamins and supplements)

Name	Dose	Frequency	Other information

IF MEDICATION LIST GOES BEYOND THE SPACE PROVIDED, THEN PLEASE ATTACH A SEPARATE SHEET

Allergies: Please list ALL allergies

Allergy	Severity	Reaction	Treatment Information

Preferred pharmacy:

Name	Pharmacy Location Number	Address	Phone Number	Fax Number

Signature _____ Date _____

Printed name _____