

Ranjit S. Grewal M.D. PA
Cy-Fair Medical Plaza
 Family Medicine
 11307 FM 1960 West, Suite 350
 Houston, Texas 77065
 Office: (281) 477-0525 / Fax: (281) 477-0526

Medical History Form

Name: _____ Birthday: _____ Date: _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Do you: Smoke? _____ Packs per day? _____ # of years smoked _____

Drink alcohol? _____ Drinks per day _____

What Pharmacy do you use? _____ Pharmacy Phone #: _____

Location of Pharmacy: _____

List the medications you are now taking:

<u>Medication</u>	<u>Dosage</u>	<u>Medication</u>	<u>Dosage</u>

List any allergies you have to drugs, food, or other items:

List all Operations:

<u>Operation Performed</u>	<u>Year</u>	<u>Hospital</u>	<u>Doctor</u>

Have you had any of the following: *(Please circle all that apply)*

Measles	Diabetes	Typhoid
Rubella (German Measles)	Goiter, Thyroid Disease	Malaria
Chickenpox	Hives	Other Tropical Diseases
Mumps	Allergies	Hepatitis
Whooping Cough	Eczema	Venereal Disease
Scarlet Fever	Mono	Seizures
Tonsillitis	Rheumatic Fever	Meningitis
Diphtheria	Poliomyelitis	Ear Infections
Asthma	Pleurisy	Heart Murmur
Glaucoma	Bronchitis	High Blood Pressure
Cancer	Influenza	Low Blood Pressure
Angina/Chest Pain	Tuberculosis	Heart Attach
Ulcer	Phlebitis	Kidney Stones
Bladder or Kidney Infection		

Please list any other serious illnesses: *(please explain)* _____

Age 50-75 Years: Colon Cancer Screen: colonoscopy or stool cards?	<u>Date:</u>	<u>Location:</u>	<u>Results:</u>
Females: Lat Pap Smear <input type="checkbox"/> NA if hysterectomy for non-cancer			
Females: Last Mammogram?			

Family History

Has anyone in your family had any of the following:

<u>Condition</u>	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Heart Disease						
Cancer						
Diabetes						
Stroke						
Mental Illness						
Lung Disease						

Signature: _____ Date: _____