RAJ & SHILPA SARALAYA, M.D., P.A.

Please complete this page to the best of your knowledge; it will assist in the development of diagnostic and therapeutic plans for your care. If you do not understand a question or do not know the answer, please leave it blank. Thank You.

- Name and age:
- Reason for seeing the doctor:
- Have you ever been told you have any of the following conditions: (circle all that apply)

Diabetes	High Calcium	Lung Disease	Asthma/Wheezing
Hypertension	Mumps	Seizures/Epilepsy	Bronchitis
Arthritis/Gout	Pneumonia	Blood Clots	HIV + Aids
Heart Disease/Murmur	Stroke	Tuberculosis	Cancer
Liver Disease	Migraines	Peptic Ulcer	Kidney Stones
Thyroid Disease	Glaucoma	Hepatitis/Jaundice	Kidney Disease
High Cholesterol	Depression	Varicose Veins	Osteoporosis
Mental Illness	Sexual Dysfunction	Bone Fractures	Menstrual Dysfunction

- List all other medical problems not mentioned above:

- Circle any problems, symptoms, or signs that you are having now:

Dizziness	Abdominal Pain	Back Pain	Bloody Stools
Night Sweats	Muscle Pain	Fevers	Weight Loss
Bone Pain	Loss of Appetite	Constipation	Joint Pain/Swelling
Blurry Vision	Diarrhea	Swollen Ankles	Black Tarry Stools
Change in Bowel Habits	Numbness/Tingling in Hands	Nosebleeds	Nausea/Vomiting
Sleep Disturbance	Weight Gain	Skin/Mole Changes	Shortness of Breath
Sinus Pain/Drainage	Weakness	Swollen Lymph Nodes	Painful Breathing/Chest Pain
Racing Heart	Neck/Thyroid Enlargement	Painful Urination	Loss of Consciousness
Hay Fever/Allergies	Hair Growth/Loss	Cough	Unsteadiness on Feet
Painful Lymph Nodes	Difficulty Starting Urination	Loss of vision	Heartburn/Indigestion
Temporary loss of vision	Vaginal Pain	Irregular Periods	Testicular Swelling
Tremor or Shakiness	Breast Pain/Swelling/Discharge	Loss of Libido or Sex Drive	Anxiety Attacks/Palpations

- List all other problems or symptoms not mentioned above:

- List your surgeries and their year performed:

- List how many times you have been hospitalized other than your surgeries:

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Circle if there is any family history of the following: (Including Parents, Grandparents, Siblings, Aunts and Uncles on both Maternal and Paternal Sides)

Diabetes	Heart Disease	Heart Attacks
High Blood Pressure	Arthritis	Osteoporosis
Early Menopause	Thyroid Disease	Liver Disease
Lung Disease	Kidney Disease	Cancer
Stroke	Rickets/Bone Disease	

- List all allergies to drug/medications/foods: _____
_____

- List all medications/dosages (including over the counter meds): _____
_____
_____
_____

- If applicable:
  Date of last Pap Smear: _____ Last Mammogram: _____

  # of Pregnancies: _____ Last Delivery Date: _____ Miscarriages: _____

- List your present doctors: _____

- Do you smoke cigarettes? YES or NO If yes, how many packs per day? _____

- Do you drink Alcohol? YES or NO If yes, how often? _____

- Do you drink Tea, Coffee, or Soda? YES or NO If so, how much? _____

- What is your occupation? _____

- List the kind of exercise that you practice (i.e. walking, jogging, aerobics, etc) _____
  _____

- Last Immunization Date: _____ Last Tetanus Shot: _____

- Last Flu Immunization: _____ Pneumonia Immunization: _____

- Last Vision Check Date: _____ Last Bone Density Date:_____

After your visit, every effort will be made to inform you of any ABNORMAL test results within 3 weeks. If you have not received any of this information, everything was normal. It takes a full three weeks to gather all the results and for the Doctors to go over them.
Please keep us informed of your current phone numbers and address.