LENOX MEDICAL CLINIC

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Sudha Challa, MD

Medical History — New Patient

Please complete this form as accurately as possible. Your provider will rely on this information to deliver safe, effective care.

PATIENT INFORMATION

Full Legal Name: _____ Date of Birth: _____ Date of Completion: _____

ADVANCE DIRECTIVES

Do you have a Living Will? ☐Yes ☐ No

Do you have a Healthcare Proxy? ☐Yes, Proxy Name (if yes): _____ ☐No

Do you have Advance Directives for Healthcare? ☐Yes ☐No — If yes, please provide a copy to our front desk staff.

CURRENT SPECIALTY PROVIDERS

Please list all specialist physicians or other providers you currently see:

	Provider Name	Specialty	Practice
1			
2			
3			

REASON FOR TODAY'S VISIT (List concerns in order of priority)

1. _____
2. _____
3. _____
4. _____
5. _____

ALLERGIES

Medication / Substance	Reaction or Side Effect

Other allergies (food, environmental, latex, contrast dye)? ☐Yes — Please describe: _____ ☐No

CURRENT MEDICATIONS (Include all prescriptions, OTC, vitamins, supplements, herbs, and birth control)

Medication Name	Dosage	Frequency	Prescribing Provider

PAST MEDICAL HISTORY (Check all that apply)

☐Acid Reflux / GERD
☐Alcoholism
☐Anemia
☐Aneurysm
☐Anxiety Disorder
☐Arthritis
☐Asthma
☐Blood Clots / DVT
☐Blood Disorder
☐Blood Transfusion
☐Bronchitis
☐Cancer (type): _____
☐Crohn's Disease
☐COPD / Emphysema
☐Diabetes (Type 1 / 2)
☐Gallbladder Disease
☐Glaucoma
☐Gout
☐Hay Fever / Allergies
☐Headaches / Migraines
☐Heart Disease
☐Heart Failure
☐Heart Murmur
☐Hepatitis A / B / C
☐High Cholesterol
☐HIV / AIDS
☐Hypertension
☐Jaundice
☐Kidney Stones
☐Obesity
☐Osteoporosis
☐Fractures
☐Prostate Problems
☐Sickle Cell Disease
☐Sleep Apnea
☐Stomach Ulcer
☐Stroke
☐Substance Abuse
☐Thyroid Disease
☐Tuberculosis
☐Ulcerative Colitis
☐STD/ STI (specify):
☐Irregular Heartbeat
☐Kidney Disease
☐Liver Disease
☐Depression
☐Epilepsy / Seizures
☐Erection Problems
☐Other: _____

Please describe or specify any checked items above if helpful: _____

PAST SURGICAL AND HOSPITALIZATION HISTORY

Operations/Procedures	Date	Hospitalizations	Date	Reason

FAMILY MEDICAL HISTORY (Major conditions in blood relatives)

☐Adopted / Unknown Family History

Family Member	Major Medical Conditions	Family Member	Major Medical Conditions
Mother		Father	
Maternal Grandmother		Paternal Grandmother	
Maternal Grandfather		Paternal Grandfather	
Sisters		Brothers	
Daughters		Sons	
Aunts		Uncles	

SOCIAL HISTORY

Occupation: _____ Marital Status: _____ Children: ☐Yes ☐No

Tobacco Use:

Currently smoke? ☐Yes. ☐No Packs/day: _____ Years smoked: _____

Former smoker? ☐Yes, ☐No Year quit: _____ Do you chew tobacco or vape? ☐Yes ☐No

Alcohol Use:

Do you drink alcohol? ☐Yes ☐No. How often: _____ Drinks per occasion: _____

Exercise:

Exercise regularly? ☐Yes ☐No Session length: _____ How often per week: _____

Recreational Drug Use:

Do you use recreational drugs? ☐Yes ☐NoIf yes, please specify: _____

Hazardous Exposure:

Worked with asbestos or hazardous materials? ☐Yes ☐NoIf yes, describe: _____

HEALTH MAINTENANCE

Last Annual Physical: _____ Last Stress Test: _____ Last Cholesterol Check: _____

Last Menstrual Period: _____ Last Pap Smear: _____ Last Mammogram: _____

Last Prostate Screening: _____ Last Colonoscopy: _____ Last Bone Density Test: _____

Immunizations (date or year received):

Immunizations: Flu _____. Pneumococcai _____ Tetanus (Tdap) _____ Hep A _____
Hep B _____ COVID-19_____. Shingles_____ Other_____

REVIEW OF SYSTEMS (Check any symptoms you have experienced recently)

☐Weight Gain/Loss	☐Runny Nose	☐Palpitations	☐Urinary Leakage	☐Anxiety/ Stress
☐Fatigue	☐Nosebleeds	☐Fainting	☐Painful Intercourse	☐MoodChanges
☐Fever / Chills	☐Cough	☐Nausea / Vomiting	☐Erection Problems	☐Depression
☐Night Sweats	☐Blood in Sputum	☐Diarrhea	☐Penis Discharge	☐Insomnia
☐Chest Discomfort	☐Shortness of Breath	☐Constipation	☐Vaginal Discharge	☐Skin Rash
☐Leg Swelling	☐Irregular Heartbeat	☐Heartburn	☐Breast Lump / Pain	☐Easy Bruising
☐Change in Vision	☐Change in Hearing	☐Blood in Stool	☐Testicular Pain	☐Joint Pain
☐Difficulty Swallowing	☐Headache	☐Dizziness	☐Back Pain	☐Leg Pain
☐Tingling / Numbness	☐Memory Problems	☐Tremors	☐Muscle Weakness	☐ Other: _____

I certify that the information provided on this form is accurate and complete to the best of my knowledge. I understand that my provider will rely on this information in making clinical decisions about my care, and I agree to update this information if my health status changes.

_____. _____ _____

Signature of Patient or Authorized Representative *Printed Name* *Date*

_____ _____

Relationship to Patient (if not patient): *Reason patient unable to sign (if applicable):*