



AMRITA

CLINIC

Centre For Laparoscopic Surgery
26/27-G, Bhai Randhir Singh Nagar, Ludhiana.

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PATIENT LABEL

OPD

Name:.....

Date:.....

UID No.:.....

New Patient

Add.....

Return Patient (Revision)

Why are you here?.....

Who Referred you to **Amrita Clinic**.....

Who is your primary care Doctor?.....

Your Cardiologist? (If any).....

Any Other Physicians?.....

Please List any Surgical Procedures or Hospitalizations :

PROCEDURE/HOSPITALIZATION	WHERE/WHEN	DOCTOR	PROBLEM

(Use Additional space at the end of this form if needed)

Present Medications (Please include prescription and/or over the counter medications)

MEDICATION	DOSAGE	MEDICATION	DOSAGE	MEDICATION	DOSAGE

Any Allergies to any Medications? _____ **NO** _____ **YES** please describe below what type of allergic reaction?

(Use Additional space at the end of this form if needed)

SYSTEM REVIEW (Please Circle if you have or have had any of the following)

General

Recent weight change
Fever/Chills
Fatigue
Night Sweats

Skin and Hair

Rashes/Scars
Skin Cancers or Melanomas
Hair Loss
Unusual lumps under Skin

Endocrine

Diabetes
Thyroid Disease
High Blood Pressure

Ears, Nose & Throat

Glass/Contacts
Double Vision
Hearing Loss
Persistent ringing in the ears
Difficulty Swallowing
Pain or Stiffness in the neck
Fullness in the neck or Throat
Hoarseness or voice change

Lungs

Shortness of breath
Emphysema or chronic bronchitis
Asthma or wheezing
Congestive heart failure
Persistent Cough
Pneumonia

Heart and Blood Vessels

Heart Attacks
Chest pain
Heart murmur
Heart Surgery
Irregular heart beat (Palpitations)
Swelling in feet
Phlebitis or blood clots
High Blood Pressure

Gastrointestinal

Difficulty Swallowing
Heartburn
Hiatal Hernia
Ulcer Disease
Jaundice
Hepatitis or other liver disorders
Colitis
Irritable bowel syndrome
Crohn's disease
Constipation
Diarrhea
Hemorrhoids/Rectal Disorders
Blood in Stool
Abdominal Pain

IF YOU ANSWER YES TO ANY OF THESE QUESTIONS, PLEASE EXPLAIN

Musculoskeletal

Arthritis
Joint Pain, Stiffness or Swelling
Decreased muscle strength
Previous bone disease
Osteoporosis
Any broken bones
Back pain/Back Surgery

Neurological

Headaches
Dizziness/Fainting
Weakness or Tingling or Arms or Legs
History of any head injury

Blood

Anemia
Blood Transfusions
If yes, When, How much and Why _____

Infections

Any serious infection
Childhood illness: _____ Measles ___ Mumps
_____ Chicken pox
Last tetanus shot _____ Last flu shot _____

For Women only:

Abnormal bleeding or discharge
Any gynecological surgery
Pain during intercourse
Kidney stones
Urinary Tract Infections
Sexually transmitted diseases (gonorrhea, syphilis, herpes, venereal warts, AIDS, etc.)

Age at time of First menstrual period _____

Number of pregnancies _____

Number of live births _____

Did you breast feed your children? _____

Average, how long? _____

Last menstrual period _____

Breasts

Breast pain
Nipple discharge
Breast lumps
Previous breast surgery
Changes in breast size

For Men Only:

Kidney stones
Prostate Disease
Difficulty urinating
Urinary tract infections
Vasectomy
Sexually transmitted diseases (gonorrhea, syphilis, herpes, venereal warts, AIDS, etc.)

LEASE LIST ILLNESSES (for which you see a Doctor or take medication)

FAMILY HISTORY :

(Please indicate if any relative has, or had)

	AGE	RELATIONSHIP
_____ Hypertension	_____	_____
_____ Diabetes	_____	_____
_____ Thyroid	_____	_____
_____ Heart Attack	_____	_____
_____ Stroke	_____	_____

FAMILY HISTORY OF CANCER :

(Please indicate if any relative has, or had)

	AGE	RELATIONSHIP
_____ Breast Cancer	_____	_____
_____ Colon Cancer	_____	_____
_____ Ovarian Cancer	_____	_____

Please specify any other history of Cancer _____

SOCIAL HISTORY :

What is your Occupation? _____ Retired _____ Disabled _____

Do you Smoke? _____ NO _____ YES How many packs a day _____ How many years? _____

Do you Drink? _____ NO _____ YES Beer _____ Alcohol _____ Drinks per Day

Do you Drink Coffee? _____ NO _____ YES _____ Cups per day

Have you ever any street drugs such as cocaine, marijuana, etc? _____ NO _____ YES please describe:

Patient Signature: _____ Date: _____



Thank you for providing complete information