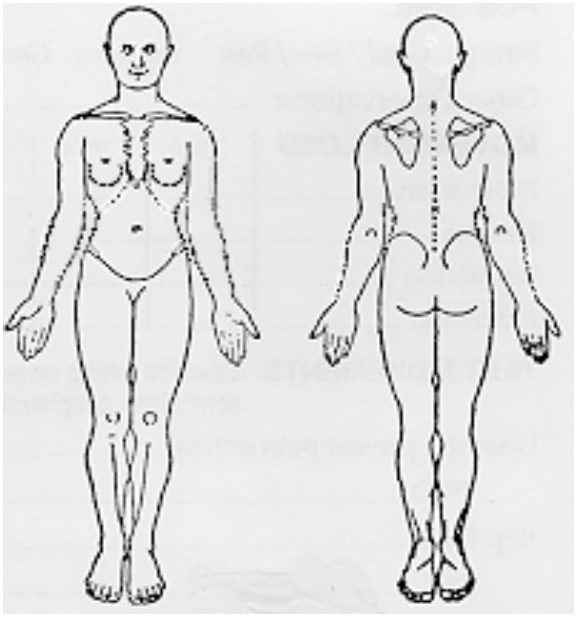
Anil S. Ranawat, M.D.
535 East 70th Street, 6th Fl., Room 636
Confidential Medical History

Name_____ Age_____ Birth date_____
Occupation_____Referred by_____

Chief complaint_____
Date of injury or onset of symptoms:_____
Describe the injury or problem:_____
_____
_____
_____



Where is your pain? Please mark the drawing.

Rate Your Pain:
0 = No pain *10 = Extreme pain*

1. Right now 0 1 2 3 4 5 6 7 8 9 10
2. At best 0 1 2 3 4 5 6 7 8 9 10
3. At worst 0 1 2 3 4 5 6 7 8 9 10

4. What makes it better?_____
_____
5. What makes it worse?_____
_____

Your Medical History
Do you have any ongoing medical problems? (diabetes, high blood pressure, etc.)_____
_____
_____
_____
Have you ever been hospitalized? Y N If yes, why?_____
_____
_____
Have you ever had surgery? Y N If yes, why and when?_____
_____
_____
Current medications:_____
_____
_____
_____
Are you allergic to any medication? Y N If yes, list. _____
_____
_____

Do you think you might be pregnant at this time? Y N
How many periods have you had during the last 12 months? **(Circle one)**
10-12 7-9 5-6 1-6 none

Family History
Does anyone in your family have any of the following problems? (please circle)

Heart disease	High blood pressure	Anesthesia complications
Cancer	Nerve problems	Blood problems (anemia, abnormal bleeding)
Stroke	Diabetes	Other:_____

Current Symptoms or Problems
Please check any of the following that apply to you:

- ◊ Recent weight change
- ◊ Fatigue/weakness
- ◊ Fever, chills
- ◊ Skin rash/disease
- ◊ Vision problems/eye disease
- ◊ Nose/throat problem
- ◊ Hearing problems/ear disease
- ◊ Frequent headaches
- ◊ Fainting spells
- ◊ Seizures
- ◊ Problems with coordination
- ◊ Depression
- ◊ Thyroid problems
- ◊ Change in appetite or thirst
- ◊ Shortness of breath or wheezing
- ◊ Frequent cough
- ◊ Chest pain
- ◊ Heart murmur
- ◊ Irregular heart beat
- ◊ Heart disease
- ◊ Swollen legs or feet
- ◊ Stomach pain or heartburn
- ◊ Ulcers
- ◊ Hepatitis or gallbladder disease
- ◊ Change in bowel habits (also blood in stools)
- ◊ Blood disorder or blood transfusion
- ◊ Easy bleeding or bruisability
- ◊ Change in urinary habits (including pain, blood in urine, trouble stopping/starting your urine)
- ◊ Kidney disease or kidney stones
- ◊ Sexually transmitted disease
- ◊ Joint stiffness, pain or swelling
- ◊ Muscle weakness
- ◊ Difficulty in moving an arm or leg

Health Habits
Do you smoke cigarettes? Y N packs/day_____ For how long? _____ yrs
Do you drink alcohol? Y N drinks/wk_____
How would you describe your level of physical activity over the past six months?
_____ Inactive - just daily activity
_____ Light - some walking, gardening, occasional weekend recreational activity
_____ Moderate - regular (3x week) moderate exercise and occasional weekend sports
_____ Vigorous - regular (3-5x week) vigorous exercise and/or sports activity
_____ Intense - competitive vigorous sports training

Height _____feet/inches Weight _____lb
Do you consider your current weight ideal? Y N
If no, list your ideal weight_____
Do you have questions about healthy ways to control your weight? Y N

Would you like us to send copies of your notes to your primary care physician? Y N
Primary Care Physician:_____
Address:_____
Phone # _____ Fax # _____