SELINA SHAH
Dance & Sports Medicine

BASS
MEDICAL GROUP

SELINA SHAH, MD A DIVISION OF BAY AREA SURGICAL SPECIALISTS MEDICAL GROUP

PATIENT HISTORY FORM

DATE _____/_____/_____ **REFERRING DOCTOR**_____

NAME _____ **PRIMARY CARE DOCTOR** _____

DOB _____ **REASON FOR VISIT** _____

MEDICATIONS		
Please list all current medications, including vitamins:		
Name of medication	**Dose**	**Frequency**

ALLERGIES	
Please list all drug allergies:	
Drug	**Reaction**

PAST MEDICAL HISTORY			
Please check whether you have or have had any of the following conditions:			
Diabetes	☐ Yes ☐ No	High cholesterol	☐ Yes ☐ No
High blood pressure/Hypertension	☐ Yes ☐ No	COPD/emphysema	☐ Yes ☐ No
Coronary artery disease	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Congestive heart failure	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Chronic renal failure	☐ Yes ☐ No	Dementia (e.g., Alzheimer's)	☐ Yes ☐ No
Sickle Cell Anemia	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No
Atrial fibrillation	☐ Yes ☐ No	Hepatitis B	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Hepatitis C	☐Yes ☐ No
Type _____		HIV	☐ Yes ☐ No
Type _____		Rheumatoid Arthritis	☐ Yes ☐ No
		Gout	☐ Yes ☐ No
		Lupus	☐ Yes ☐ No
Others:			

PAST SURGICAL HISTORY			
Please list all prior surgeries:			
Surgery	**Year**	**Surgery**	**Year**

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FAMILY HISTORY			
Please answer the following questions about your family members:			
Father	☐ Alive ☐ Deceased	Age (or age at death):	Cause of death:
	Please list any significant medical problems (if any):		
Mother	☐ Alive ☐ Deceased	Age (or age at death):	Cause of death:
	Please list any significant medical problems (if any):		
Sister	Please list any significant medical problems (if any):		
Brother	Please list any significant medical problems (if any):		
Other Family	Please list any significant medical problems of other relatives (e.g., grandparents, uncles, aunts, etc.)		
Additional Space for Family History:			

SOCIAL HISTORY		
Drinks Alcohol	Do you drink alcohol? ☐ Yes ☐ No If yes how often? Daily ☐ Weekly ☐ Monthly ☐ Socially ☐ Rarely ☐	
	☐ Beer ☐ Wine ☐ Liquor Amount? When was your last drink?	
Tobacco Use	Do you smoke? ☐ Yes ☐ No If yes, how many packs per day?	
	How many years did you smoke?	What year did you quit?
Drug Use	Do you currently use recreational drugs? ☐ Yes ☐ No Have you in the past? ☐ Yes ☐ No	
	Have you ever used intravenous drugs? ☐ Yes ☐ No	
Caffeine Use	If yes, what kind? Please check: Coffee ☐ Soda ☐ Chocolate ☐ Tea ☐ Other ☐ How many cups? How many sodas?	
Employment	Occupation (past or present):	
Social History	Marital Status, please check: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Who Lives in your home with you? _____ Do you have children? _____ If so how many _____	
Miscellaneous	Have you ever received a blood transfusion? ☐ Yes ☐ No	

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REVIEW OF SYSTEMS

Please check whether you have any of the following problems, either CURRENTLY OR REPEATEDLY:

Constitutional

Fever	☐ Yes	☐ No
Headache	☐ Yes	☐ No
Unexplained weight loss	☐ Yes	☐ No

Other: _____

HEENT

Runny nose	☐ Yes	☐ No
Difficulty hearing	☐ Yes	☐ No
Sore Throat	☐ Yes	☐ No

Other: _____

Neurologic/Psychiatric

Numbness	☐ Yes	☐ No
Tingling	☐ Yes	☐ No
Weakness	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Memory loss	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Spinal cord injury	☐ Yes	☐ No
Headache	☐ Yes	☐ No
Difficulty Sleeping	☐ Yes	☐ No

Other: _____

Metabolic/Endocrine

Excessive thirst	☐ Yes	☐ No
Too hot	☐ Yes	☐ No
Too cold	☐ Yes	☐ No

Other: _____

Immunologic

Hay fever	☐ Yes	☐ No
Food allergies	☐ Yes	☐ No

Other: _____

Respiratory

Shortness of breath	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Cough	☐ Yes	☐ No

Other _____

Musculoskeletal

Joint pain	☐ Yes	☐ No
Back pain	☐ Yes	☐ No
Artificial joints	☐ Yes	☐ No

Other: _____

Cardiovascular

Chest pain	☐ Yes	☐ No
Irregular pulse	☐ Yes	☐ No
Heart attack	☐ Yes	☐ No

Other: _____

Hematalogic

Easy bruising or bleeding	☐ Yes	☐ No
Blood clots in arms or legs	☐ Yes	☐ No
Anemia	☐ Yes	☐ No

Other: _____

Gastrointestinal

Abdominal pain	☐ Yes	☐ No
Nausea/vomiting	☐ Yes	☐ No
Indigestion/heartburn	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No

Other: _____

Genitourinary

Cloudy Urine	☐ Yes	☐ No
Blood in Urine	☐ Yes	☐ No

Other: _____

Vascular

Cool Extremity	☐ Yes	☐ No
Pain in limb	☐ Yes	☐ No
Varicose Veins	☐ Yes	☐ No

Other: _____

Dermatologic

Rash	☐ Yes	☐ No
Boils / Infections	☐ Yes	☐ No

Other: _____