Desert Rose Medical Consultants, PC

Veena Gulaya, MD
Devendra Gulaya,MD

Welcome to our practice.

NAME		DOB :	SEX : M F
PHONE		MARITAL STATUS	
OCCUPATION		EDUCATION	
EMERGENCY CONTACT		PHONE NO.	
NAME OF LAST PHYSICIAN		LAST SEEN	
PHARMACY NAME:		PHARMACY PH NUMBER :	

PLEASE TAKE A MOMENT TO COMPLETE THE MEDICAL HISTORY SO WE CAN TREAT YOU MORE EFFECTIVELY-You may use back side of this page for additional space. Please sign and date pages 2-3

Today's visit is for:____

If we have time, I'd also like to discuss:____

Medications / Medical History

☐ **NONE**

CURRENT MEDICATIONS (INCLUDE VITAMINS, SUPPLEMENTS, AND OVER THE COUNTER MEDS)	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

MEDICAL HISTORY / CURRENT MEDICAL PROBLEMS (CHECK ALL THAT APPLY, FILL IN ANY OTHERS)

- ☐ **NONE**
- ❑ High Blood Pressure
- ❑ Diabetes
- ❑ High Cholesterol ____________________
- ❑ Heart Problems: ____________
- ❑ ________________________
- ❑ ________________________
- ❑ Prostate Problems
- ❑ Depression
- ❑ Stomach/GI problems:___________________
- ❑ Cancer, type:________________
- ❑ ____________________________
- ❑ ____________________________
- ❑ ____________________________
- ❑ ____________________________

ALLERGIES YES NO	If yes, then complete below
NAME OF MEDICATION	TYPE OF REACTION
	❑ rash ❑difficulty breathing ❑ stomach pain/vomiting ❑ other:
	❑ rash ❑difficulty breathing ❑ stomach pain/vomiting ❑ other:
	❑ rash ❑difficulty breathing ❑ stomach pain/vomiting ❑ other:

TYPE OF SURGERY	SURGEON	HOSPITAL	DATE

HOSPITALIZATIONS (DO NOT INCLUDE SURGERIES LISTED ABOVE)

REASON	DOCTOR	HOSPITAL	DATE

FAMILY MEDICAL HISTORY (PLEASE ADD ANY OTHERS NOT LISTED)

Conditions/Problems	*Family Members affected and exact nature of problems*
❑ Diabetes	
❑ High Blood Pressure	
❑ Heart Problems	
❑ Cancer	
❑ High Cholesterol	

SOCIAL HISTORY / HABITS

❑ **Smoker**: _____ packs/day ❑ Non-smoker ❑ Quit smoking in ______
Alcohol use: ❑ Yes (drinks/week:_____________) ❑ No
❑ **Substance Abuse** ________________________
❑ I **exercise** regularly ❑ I exercise rarely ❑ I do not exercise
❑ I **have/ have** not traveled outside the United States in the past three months

HEALTH MAINTENANCE

Last Physical/Pap/Prostate	Eye Exam	Dental Exam
Last Tetanus Shot	Pneumonia Shot	Hepatitis B Immunization
Last Mammogram	Bone Density	
Last Colorectal Cancer Screening Colonoscopy/Flex Sig :		

OBSTETRIC HISTORY

No of Pregnancies	Method of Birth Control (If any)

How did you hear about us?____

NAME _________________________**SIGNATURE**_______________**DATE**_____

Advanced Directives ☐ **Yes** ☐ **No** **If yes, then please provide a copy**

PLEASE TAKE A MOMENT TO ANSWER THESE IMPORTANT QUESTIONS -Mandatory

Have you been discharged from any practice?	**YES/NO**
If yes, then reason -	

Narcotic Policy
As a rule per our office policy we do not prescribe controlled substances without proper documentation from previous physician of appropriate compliance related to those medications.
You are responsible for providing that documentation. **You may need to reschedule your appointment till that documentation is available.**

Is any of your medical condition(s) secondary to workman's compensation or accident injury?	**YES/NO**
If yes, give details:	

Do you have any ongoing/ pending medico-legal litigation?	**YES/NO**
If yes, give details:	
Are you on Medical Disability?_______________________________	YES/NO______

Please note that we do not do any medical disability evaluations/assessments and accident related injury evaluations and treatment. If you are here for that reason then you may need to see a different physician that does such evaluations.

Please list all physicians you are currently seeing

Name	Specialty	Reason	Last seen

NAME ____________________________SIGNATURE_________________DATE______