

Vinod K. Anand, M.D.

The Colonnades
501 Marshall Street – Suite 602, Jackson, MS 39202
Telephone: (601) 969-1910

New Patient Medical History Questionnaire

Personal Information

Name: _____ Sex: _____ Age: _____

Occupation: _____

Medical Information

Name of Referring Physician: _____

Have you ever experienced an unusual or allergic reaction to any substance or drug such as penicillin, codeine or other drugs, medicines, metals, wasps, bees, pollen, etc.? YES NO

Have you been seen by a physician in the last 12 months? YES NO
Name of physician: _____

Are you now taking any medicine (including shots)? YES NO

Please list: _____

Reason for this appointment: _____

Do you now have, or have you ever had the following:

Heart trouble or murmur	YES	NO
Rheumatic fever	YES	NO
Stomach/duodenal ulcer	YES	NO
Stroke	YES	NO
High blood pressure	YES	NO
Diabetes (high blood sugar)	YES	NO
Kidney problems	YES	NO
Hepatitis or liver disease	YES	NO

Convulsion or epileptic seizures	YES	NO
Bleeding disorder	YES	NO
Sickle cell disease or trait	YES	NO
Anemia	YES	NO
Thyroid disease	YES	NO
Tumor or cancer	YES	NO
Asthma	YES	NO
Tuberculosis	YES	NO
Emotional problems, treated by medication or hospitalization	YES	NO
Venereal disease, syphilis, gonorrhea, AIDS	YES	NO
Hearing loss	YES	NO
Glaucoma	YES	NO
Physical handicap	YES	NO
Have you ever used cocaine, marijuana, heroin or similar drugs?	YES	NO
Have you ever smoked or used tobacco in any form?	YES	NO
How much? _____		
Have you ever drank alcoholic beverages?	YES	NO
How much? _____		
Have you any reason to suspect you may have been exposed to the HIV Virus (AIDS)?	YES	NO
Is there anything we should know about your health that is not covered by these questions?	YES	NO

PATIENT OR GUARDIAN: _____

PHYSICIAN: _____

DATE: _____