



345 Clyde Morris Blvd Suite 390
Ormond Beach FL, 32174
386-673-0075

GUPTA MEDICAL SPECIALISTS

NEW PATIENT INFORMATION FORM -*ENDO*

Please print all information. Thank you for your cooperation.

Patient Name: _____

Date of Birth: _____ Social Security # _____

Address: _____

City: _____

State: _____ Zip Code: _____

Phone (home): _____ Work/Cell: _____

Employer: _____

Marital Status: Single Married Divorced Widowed

Email Address: _____

Is it ok to mail correspondence such as reminders and letters to you? ___ Yes ___ No

Referring Physician or Referral Source:

Primary Care Physician:

Do you want your medical records sent to this practice? ___ Yes ___ No

Insurance Plan: _____

Group Number: _____ Policy Number: _____

Issue Date: _____

Secondary Insurance Plan: _____

Group Number: _____ Policy Number: _____

Issue Date: _____

Thank you for taking the time to complete our intake forms. Please sign & date (below)

Patient's Signature

Today's Date

HISTORY OF PRESENT ILLNESS

1. Age:_____ Male Female

2. What medical problem are you being seen for?

3. When were you diagnosed?

4. How were you diagnosed?

5. What are you being treated with?

6. Have you had any imaging (xray, MRI, ultrasound, etc) done for this area?

If so, where and when?

SOCIAL HISTORY

1. Current work status _____ Occupation: _____
 2. Marital Status: Single Married Divorced Widowed
 3. Number of Children: _____
 4. I live: Alone With: _____ I live in a: House Apartment Nursing Facility
 5. Are you a cigarette smoker? No Yes How old were you when you began smoking? _____
 How much do you smoke daily? _____ When did you quit smoking? _____
 6. Do you drink any alcoholic beverages: (check one) No Yes
 1 2 3 4 5 6 drinks daily weekly monthly social use only
 7. Have you ever had a problem with drug dependence? Yes No
 8. Please write any additional information that you feel is important for us to know.
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REVIEW OF SYTEMS

Do you currently have any of the following medical symptoms?

General

- Unexplained weight loss
- Appetite change
- Fevers or chills
- Night sweats
- Marked fatigue
- Difficulty sleeping

Eyes

- Glasses
- Change in vision
- Double vision

Ear, Nose, Throat

- Difficulty swallowing
- Hoarseness
- Loss of hearing
- Ear pain
- Nosebleeds

Cardiovascular

- Heart or chest pain
- Abnormal heartbeat
- Leg swelling

Respiratory

- Morning cough
- Shortness of breath
- Productive cough or sputum

Digestive

- Nausea or vomiting
- Stomach pain or ulcers
- Heart burn
- Diarrhea
- Constipation
- Uncontrolled loss of stool
- Blood in stools

Skin

- Rashes
- Itchiness
- Easy bruising

Neurological

- Seizures
- Blackouts/fainting
- Headaches/migraines

Musculoskeletal

- Joint pains
- Joint swelling
- Numbness in feet/hands
- Muscle weakness

Genitourinary

- Burning on urination
- Incontinence
- Pelvic pain
- Impotence
- Abnormal Bleeding

Psychiatric

- Depression
- Anxiety
- Paranoia

Other
