One Sears Drive, Suite #402

Paramus, NJ 07652

☎: 201-483-9188

Fax: 201-483-9189

Amit Agarwal MD PC

Sonia Chadha MD

NEW PATIENT DEMOGRAPHICS FORM

Last Name: _____ Middle: _____ First: _____

Street: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Social Security #: _____

Cell Number: _____ Work Number: _____

Best Phone number to reach you: _____

May we leave a detailed message? Yes / No (Circle the option)

If yes, at which phone number? _____

Gender: _____ DOB: _____ Age: _____

Marital Status: _____ Email Address: _____

Emergency Contact:

Name: _____ Relationship: _____

Street: _____ City: _____ State: _____ Zip: _____

Phone Number: _____

Employment Information:

Status: _____

Street: _____ City: _____ State: _____ Zip: _____

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PATIENT AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security # _____

I request and authorize _____ to release

health care information of the patient named above to:

Dr. Amit Agarwal and Dr. Sonia Chadha

One Sears Drive, Suite # 402, Paramus NJ 07652

This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or

dates: _____

All Healthcare information:

Other: _____

Definition: Sexually Transmitted Diseases (STD) as defined by law, RCW 70.24 et seq, includes herpes, herpes simplex, human papilloma virus, genital warts, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome). And gonorrhea.

_____ _____

Patient Signature **Date**

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PATIENT LIABILITY FORM

To Whom It May Concern:

I, _____ understand I will be fully liable for any expenses not covered by my insurance carrier for services provided by my health care professional.

_____ _____

Signature **Date**

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NEW PATIENT COMPLETE HISTORY FORM **DATE: _____**

A. **PERSONAL HEALTH HISTORY**:

1. List all Operations and Dates:

	OPERATION	DATE	WHERE PERFORMED	DOCTOR
1				
2				
3				
4				
5				
6				

Past Medical History (check ✓ any you have had)

☐ Measles ☐ German Measles ☐ Diphtheria ☐ Heart Disease
☐ Mumps ☐ Diabetes ☐ Rheumatic Fever ☐ Kidney Disease
☐ Alleged Abuse ☐ Physical or Mental Disability

List below any major injuries, broken bones or hospitalizations not listed above. Also, list any major or chronic illnesses you have at present or have had, (i.e. arthritis, high blood pressure, nervous condition, seizures, etc.)

	ILLNESS	APPROXIMATE DATES
1		
2		
3		
4		
5		
6		

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2. Children:

				WOMEN ONLY	
	DATES OF BIRTH	**SEX**	**HEALTH PROBLEMS**	**BIRTH WEIGHT**	**PROBLEMS WITH PREGNANCY or DELIVERY**
1					
2					
3					
4					
5					
6					

3. Menstrual History (Women Only)

A. Age of onset: _____

B. Usual Cycle every _____ days/weeks x _____ days

C. Present Contraception _____

Obstetrical History Para _____

Significant Complications _____

_____

Previous Mammogram Yes No If Yes, Date _____

Previous Pap Smear Yes No If Yes, Date _____

Previous Abnormal Pap Smear Yes No If Yes, Date _____

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B. FAMILY HISTORY:

FAMILY MEMBER	IF LIVING			IF DECEASED		
	AGE	CONDITION OF HEALTH FAIR OR POOR	HISTORY OF ALLERGY, DIABETES, CANCER, EPILEPSY, HEART DISEASE, HYPERTENSION, MENTAL ILLNESS, T.B. ETC	DATE	AGE AT DEATH	CAUSE
Father						
Mother						
Brothers						
Sisters						
Paternal Grandfather						
Paternal Grandmother						
Maternal Grandfather						
Maternal Grandmother						
Others, specify						

C. IMMUNIZATION RECORD:

	DATE
Diphtheria	
Tetanus	
Pertussis	
Polio	
Hepatitis A	
Measles	
Rubella	
Hepatitis B	
Pneumovax	
Mantoux	
Result	
Influenza	

ALLERGIES: To medications, food, and contact. Please list all.

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PERIODIC INTAKE FORM:

This is a confidential questionnaire. Answer it to the best of your ability. If you are in doubt about an answer, pencil in a question mark (?). This is designed for your benefit and your efforts in completing it will help us give you the best possible medical care.

1. LIST CONCISELY SPECIFIC SYMPTOMS OR PROBLEMS YOU WANT INVESTIGATED ON THIS EXAM:

1.
2.
3.
4.
5.

2. List all medications – pills or liquid presently being taken – including vitamins, minerals, or other nutritional supplements.

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

3. Are you on a special diet? ☐ Yes ☐ No If yes, what kind? _____

4. Occupation: ☐ Full-Time ☐ Part-Time Hours per week: _____

5. Describe briefly what you do on your job: _____

6. Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow(er)

7. Who lives in your household? _____

8. Have you traveled abroad in the past year? ☐ Yes ☐ No

   If yes, destination _____

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9. Habits (indicate amount consumed of the following):

1. Cigarettes/smokeless _____ packs/day
2. Cigars or pipe loads _____ per day
3. Coffee _____ cups/day
4. Cola Beverages _____ bottles/cans per day
5. Cocktails or straight drinks _____ per week
6. Beers (3.2% or stronger) _____ per week
7. What % of time in your vehicle do you wear seat belts? _____ %

10. Method of Birth Control (if applicable) _____

11. Exercise (for example: walking, jogging, golf, tennis, handball, calisthenics etc.):

TYPE	NUMBER OF TIMES PER WEEK

12. WOMEN ONLY:

Menstrual Periods: ☐ Heavy ☐ Average ☐ Light

Last Menstrual Period _____

Interval between periods _____ Days of flow _____

13. Do you have any sexual concerns you wish to discuss? ☐ Yes ☐ No

If yes, please provide a brief description: _____

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14. Educational Needs:

☐ Yes	☐ No	Patient is aware of diet, exercise and lifestyle conducive to osteoporosis prevention
☐ Yes	☐ No	Patient is aware of need for monthly breast self-exam and proper technique
☐ Yes	☐ No	Patient is aware of importance of protection against STDs by monogamy or “safe sex”
☐ Yes	☐ No	Patient is aware of current recommendations for routine mammogram and Pap Smears
☐ Yes	☐ No	Patient is aware of importance of seatbelt use

15. CHECK SYMPTOMS TO WHICH YOU ARE SUBJECT:

☐ Blurred Vision	☐ Swelling of Legs	☐ Dribbling
☐ Eye pain	☐ Pain in legs with exercise	☐ Need to void more than once at night
☐ Deafness	☐ High blood pressure	☐ Blood in urine
☐ Ringing in ears	☐ Positive TB (Mantoux) skin test	☐ Loss of force of stream
☐ Hay fever	☐ Loss of appetite or weight	☐ Spotting with intercourse
☐ Nosebleeds	☐ Special diet	☐ Painful intercourse
☐ Sinus infections	☐ Constipation	☐ Vaginal discharge
☐ Hoarseness	☐ Heartburn	☐ Urethral discharge
☐ Difficulty swallowing	☐ Gaseousness	☐ Frequent headaches
☐ Excessive thirst	☐ Pain in abdomen	☐ Dizziness
☐ Asthma (Wheezing)	☐ Vomiting	☐ Numbness
☐ Persistent cough	☐ Diarrhea	☐ Nervousness
☐ Blood phlegm	☐ Black or bloody stools	☐ Insomnia
☐ Shortness of breath with flight of stairs	☐ Distress from spicy or fatty foods	☐ Convulsions
☐ Shortness of breath at night	☐ Change in bowel habits	☐ Fainting spells
☐ Chest pain with cough	☐ Frequent voiding (passing urine)	☐ Crying spells
☐ Chest discomfort with exercise	☐ Painful voiding	☐ Joint pains
☐ Palpitation	☐ Urgent voiding	☐ Back pains

Use lines below for further explanation of any symptoms checked above:

_____

_____

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MEDICATION LIST

Pharmacy Name: _____

Pharmacy Phone #: _____

Allergies: _____

Medication	Dosage	Date Started	End Date