



Dr. Rajsree Nambudripad, MD, ABIHM  
Dr. Roy Nambudripad, MD

**NEW PATIENT HISTORY FORM**

Name \_\_\_\_\_ Date \_\_\_\_\_ File No. \_\_\_\_\_  
Phone number \_\_\_\_\_ Email \_\_\_\_\_  
Home address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Sex M \_\_\_ F \_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work phone \_\_\_\_\_  
Work address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Marrital status M S D W Number of children \_\_\_\_ Boys \_\_\_ Girls \_\_\_\_  
Name of spouse \_\_\_\_\_ Referred by \_\_\_\_\_  
Spouse's employer \_\_\_\_\_ Spouse's occupation \_\_\_\_\_

If patient is a child, please fill out above work information for parent, or whoever is financially responsible.

Medical Insurance: Yes \_\_\_ No \_\_\_ Insurance Co. Name \_\_\_\_\_

Our office does not bill insurance, but if you have a PPO insurance, we provide superbills that you can file with your insurance company to get reimbursement directly. Our doctors have opted out of Medicare. We try to use your insurance (including Medicare) for lab or imaging tests when possible.

What is your main problem? How long have you had this problem? Please describe in detail.

What do you believe caused this condition?

What are your health goals?

List your medical problems in order of severity and describe any past treatments.

What medications do you take? Please list all medications (prescription and over the counter), vitamins, and herbal supplements. Include doses if you know them.

What foods allergies or sensitivities do you have? Please describe the reaction as well.

What medication allergies or sensitivities do you have? Please describe the reaction as well.

What environmental allergies do you have? Please describe the reaction as well.

Have you ever had an anaphylactic reaction? Yes\_\_\_\_ No\_\_\_\_. If yes, please describe the situation.

What surgeries have you had? Please include the dates or your age at the time of surgery.

Have you ever been hospitalized? For what reason?

Describe any childhood illnesses (for example - childhood asthma).

Do you currently smoke? Yes \_\_\_ No \_\_\_. If yes, how many cigarettes per day? \_\_\_\_\_  
 Have you ever smoked in the past? Yes \_\_\_ No \_\_\_\_\_. If yes, for how many years \_\_\_\_\_  
 Do you drink alcohol? Yes \_\_\_ No \_\_\_\_\_. Number of drinks \_\_\_\_\_ per \_\_\_\_\_ week or month  
 Type of alcohol consumed (beer, wine, hard liquor): \_\_\_\_\_  
 Is alcohol an important part of your social life? \_\_\_\_\_  
 Do you currently use marijuana? Yes \_\_\_ No \_\_\_\_\_. Prior marijuana use? Yes \_\_\_ No \_\_\_\_\_.  
 Have you ever used other drugs like cocaine, heroin, amphetamines, etc? \_\_\_\_\_

Please describe any past and present life stressors. For example, include any traumatic events, stress from relationships, stress from work, and financial hardships.

How many hours of sleep do you get per night? \_\_\_\_\_  
 Do you have difficulty falling asleep? \_\_\_\_\_ staying asleep? \_\_\_\_\_  
 Do you feel rested upon awakening? \_\_\_\_\_

How do you relax? What are your hobbies?

Do you exercise? Yes \_\_\_ No \_\_\_\_\_.  
 How often? Regularly \_\_\_ Infrequently \_\_\_ Seldom \_\_\_  
 What type of exercise?

Regarding your diet:

- I have no dietary restrictions.
- I am vegetarian.
- I am vegan.
- I follow a gluten-free diet.
- I avoid certain foods. Please list the foods you avoid: \_\_\_\_\_  
 \_\_\_\_\_

What is your current weight? \_\_\_\_\_ What is your goal weight? \_\_\_\_\_

Please describe your typical diet as below:

Breakfast:

Lunch:

Dinner:

Dessert:

Snacks:

Beverages:

Do you skip meals? \_\_\_\_\_ Skip breakfast? \_\_\_\_\_  
 How often do you eat in restaurants? \_\_\_\_\_  
 Do you consume fast food? \_\_\_\_\_  
 Do you prepare your own food? \_\_\_\_\_ Who prepares your food? \_\_\_\_\_  
 Do you buy organic foods? \_\_\_\_\_  
 Do you avoid GMO (genetically modified) foods? \_\_\_\_\_  
 What type of cookware do you use (stainless steel, cast iron, non-stick, ceramic)? \_\_\_\_\_  
 How many caffeinated beverages do you drink per day? \_\_\_\_\_  
 Do you crave sugar or carbs? \_\_\_\_\_  
 Do you do late night snacking? \_\_\_\_\_  
 Are you an emotional eater (eat when sad, lonely, depressed or bored)? \_\_\_\_\_

Who is your primary care doctor?  
 Office location:  
 When was your last physical exam?

List your other doctors and health care providers (specialists, acupuncturists, chiropractors, etc).

Health Maintenance Issues:

When was your last:

Colonoscopy \_\_\_\_\_

Flu shot \_\_\_\_\_

Tetanus shot \_\_\_\_\_

Cholesterol checked \_\_\_\_\_

General blood tests \_\_\_\_\_

For Women:

When was your last:

Mammogram \_\_\_\_\_

PAP Smear \_\_\_\_\_

Last menstrual period \_\_\_\_\_

Are you pregnant now? Yes \_\_\_ No \_\_\_

Family History:

Please tell us if your family members have had heart disease, cancer (specify type), diabetes, allergies, autoimmune disease (specify type), lung disease, skin issues, hormonal issues, heavy metal toxicity, or any other health issues.

Mother's age \_\_\_\_\_ Health problems \_\_\_\_\_

Father's age \_\_\_\_\_ Health problems \_\_\_\_\_

Sibling's age \_\_\_\_\_ Health problems \_\_\_\_\_

Sibling's age \_\_\_\_\_ Health problems \_\_\_\_\_

Sibling's age \_\_\_\_\_ Health problems \_\_\_\_\_

Sibling's age \_\_\_\_\_ Health problems \_\_\_\_\_

Any recent camping or travel outside the United States? Where did you go?

Do you have any mechanical devices in your body, like shunts, hearing aids, pacemaker, ear tubes, implants, IUD, etc?

Exposures:

Do you suspect mold exposure in your home or at work? \_\_\_\_\_

Do you dry clean your clothes? \_\_\_\_\_

Do you use plastic containers to store your foods? \_\_\_\_\_

Do you have dental fillings or root canals? \_\_\_\_\_

Do you read ingredients labels on lotions and cosmetics? \_\_\_\_\_

Do you use green house cleaning products? \_\_\_\_\_

Do you suspect toxin exposure from another source? \_\_\_\_\_

For pediatric patients, please describe vaccine schedule (routine schedule, modified or delayed, or no vaccines) and provide copy of immunization card. Any adverse reaction to any immunization?

Please elaborate on anything else you feel is important for your doctors to know in order to provide the best care.

**Please Check any Current or Recent Symptoms:**

<p align="center"><b>General</b></p> <ul style="list-style-type: none"> <li>○ Weight loss</li> <li>○ Weight gain</li> <li>○ Fatigue</li> <li>○ Fever</li> <li>○ Chills</li> <li>○ Weakness</li> <li>○ Trouble sleeping</li> </ul> <p align="center"><b>Skin</b></p> <ul style="list-style-type: none"> <li>○ Hives</li> <li>○ Eczema</li> <li>○ Psoriasis</li> <li>○ Other rash</li> <li>○ Lumps</li> <li>○ Acne</li> <li>○ Itching</li> <li>○ Dry skin</li> <li>○ Color changes in skin</li> <li>○ Hair loss</li> <li>○ Abnormal hair growth</li> <li>○ Premature graying</li> <li>○ Dandruff</li> <li>○ Nail changes</li> </ul> <p align="center"><b>Head, Ears, Nose</b></p> <ul style="list-style-type: none"> <li>○ Headaches</li> <li>○ Head injury</li> <li>○ Sensitivity to light</li> <li>○ Sensitivity to sounds</li> <li>○ Decreased hearing</li> <li>○ Ringing in the ears (tinnitus)</li> <li>○ Earache</li> <li>○ Ear drainage</li> <li>○ Problems with vision</li> <li>○ Watery or itchy eyes</li> <li>○ Floaters in vision</li> <li>○ Glaucoma</li> <li>○ Cataracts</li> <li>○ Nasal congestion</li> <li>○ Postnasal drip</li> <li>○ Nose bleeds</li> <li>○ Sinus pain or infections</li> <li>○ Sneezing</li> <li>○ Dry mouth</li> <li>○ Hoarseness</li> <li>○ Thrush</li> <li>○ Mouth sores</li> <li>○ Bad breath</li> <li>○ Dental decay</li> <li>○ Bleeding gums</li> <li>○ Gum disease</li> <li>○ Sore throat</li> <li>○ Hoarseness</li> </ul> <p align="center"><b>Neck Symptoms</b></p> <ul style="list-style-type: none"> <li>○ Lumps in neck</li> <li>○ Swollen glands</li> <li>○ Pain in neck</li> <li>○ Stiffness in neck</li> </ul>	<p align="center"><b>Breasts</b></p> <ul style="list-style-type: none"> <li>○ Breast lumps</li> <li>○ Breast pain</li> <li>○ Breast discharge</li> </ul> <p align="center"><b>Lungs</b></p> <ul style="list-style-type: none"> <li>○ Asthma</li> <li>○ Dry cough</li> <li>○ Productive cough</li> <li>○ Coughing up blood</li> <li>○ Shortness of breath at rest</li> <li>○ Wheezing</li> <li>○ Painful breathing</li> </ul> <p align="center"><b>Heart</b></p> <ul style="list-style-type: none"> <li>○ Chest pain or discomfort</li> <li>○ Chest tightness</li> <li>○ Irregular heart beat</li> <li>○ Shortness of breath with activity</li> <li>○ Difficulty breathing when lying down</li> <li>○ Swelling in legs</li> <li>○ Sudden awakening from sleep with shortness of breath</li> <li>○ High blood pressure</li> <li>○ Low blood pressure</li> </ul> <p align="center"><b>GI tract</b></p> <ul style="list-style-type: none"> <li>○ Difficulty swallowing</li> <li>○ Heartburn</li> <li>○ Increased appetite</li> <li>○ Decreased appetite</li> <li>○ Nausea</li> <li>○ Vomiting</li> <li>○ Constipation</li> <li>○ Diarrhea</li> <li>○ Blood in stools</li> <li>○ Yellow skin or eyes</li> <li>○ Abdominal pain</li> <li>○ Bloating</li> <li>○ Hemorrhoids</li> </ul> <p align="center"><b>Urinary Tract</b></p> <ul style="list-style-type: none"> <li>○ Frequent urination</li> <li>○ Burning with urination</li> <li>○ Incontinence</li> <li>○ Blood in the urine</li> <li>○ Prostate abnormalities</li> </ul> <p align="center"><b>Reproductive</b></p> <ul style="list-style-type: none"> <li>○ Vaginal or penile discharge</li> <li>○ Sores in genital region</li> <li>○ Sexually transmitted diseases</li> <li>○ Yeast infection</li> <li>○ Pain with intercourse</li> <li>○ Decreased libido</li> <li>○ PMS (premenstrual syndrome)</li> <li>○ Infertility</li> <li>○ Irregular menses</li> <li>○ Heavy menses</li> <li>○ Painful menses</li> </ul>	<p align="center"><b>Vascular</b></p> <ul style="list-style-type: none"> <li>○ Calf pain when walking</li> <li>○ Leg cramping</li> <li>○ Varicose veins</li> </ul> <p align="center"><b>Musculoskeletal</b></p> <ul style="list-style-type: none"> <li>○ Muscle pain</li> <li>○ Joint pain</li> <li>○ Stiffness</li> <li>○ Back pain</li> <li>○ Swelling of joints</li> <li>○ Injury to joints</li> <li>○ Redness of joints</li> <li>○ Hip pain</li> <li>○ Knee pain</li> <li>○ Shoulder pain</li> </ul> <p align="center"><b>Neurologic</b></p> <ul style="list-style-type: none"> <li>○ Dizziness</li> <li>○ Fainting</li> <li>○ Seizures</li> <li>○ Weakness</li> <li>○ Numbness</li> <li>○ Tingling</li> <li>○ Tremor</li> <li>○ Migraine headaches</li> <li>○ Brain fog</li> <li>○ Daytime drowsiness</li> </ul> <p align="center"><b>Hematologic</b></p> <ul style="list-style-type: none"> <li>○ Anemia</li> <li>○ Easy bruising</li> <li>○ Cuts heal slowly</li> <li>○ Bleeding problem</li> </ul> <p align="center"><b>Hormonal</b></p> <ul style="list-style-type: none"> <li>○ Intolerance to heat</li> <li>○ Intolerance to cold</li> <li>○ Frequent urination</li> <li>○ Excess thirst</li> <li>○ Hot flashes</li> </ul> <p align="center"><b>Mental Health</b></p> <ul style="list-style-type: none"> <li>○ Depression</li> <li>○ Anxiety</li> <li>○ Memory loss</li> <li>○ Suicidal thoughts</li> <li>○ Bipolar disorder</li> <li>○ Attention deficit</li> <li>○ Anger outbursts</li> <li>○ Compulsive behavior</li> <li>○ Emotional imbalances</li> <li>○ Hyperactive</li> <li>○ Phobias</li> </ul> <p align="center"><b>Other</b></p> <ul style="list-style-type: none"> <li>○ Craving for sweets</li> <li>○ Craving for salty food</li> <li>○ Craving for spices</li> <li>○ Crave coffee or caffeine</li> <li>○ Crave sour or bitter</li> </ul>
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