U.S. De Silva, MD
A Medical Corporation
623 W Ave Q, Suite A
Palmdale, CA 93551

Date: ___/___/_____

Last Name:_____ First Name, MI:_____

Sex: ___Male ___Female Date of birth: ____/____/_____

Social Security Number (optional): _____-_____-_____

Check appropriate box: ___minor ___single ___married ___divorced

___widowed ____separated

Occupation: _____Employer:_____

Referred by: _____

Present illness: _____

Duration: _____

Additional complaints: _____

Past illnesses: _____

Past surgeries: _____

Do you: ___smoke ___drink alcohol ___abuse drugs

If yes, how much?: _____

Allergies (to medication or food):_____

_____

Current medications: _____

_____

Have you had any of the following?

Cancer: ____Yes ____No

Tuberculosis: ____Yes ____No

Diabetes: ____Yes ____No

Heart trouble: ____Yes ____No

High blood pressure: ____Yes ____No

Stroke: ____Yes ____No

Convulsions: ____Yes ____No

Bleeding disorder: ____Yes ____No

Kidney disease: ____Yes ____No

Psychiatric problems: ____Yes ____No

Pulmonary problems: ____Yes ____No

Arthritis: ____Yes ____No

General

Recent weight change: ____Yes ____No

Fever or chills: ____Yes ____No

Hives, eczema or rash: ____Yes ____No

Frequent infection or boils: ____Yes ____No

Abnormal pigmentation: ____Yes ____No

Hemorrhoids or piles: ____Yes ____No

Pain in abdomen: ____Yes ____No

Food sticking in throat: ____Yes ____No

Constipation: ____Yes ____No

Hands, Eyes, Ears, Nose and Throat

Eye disease or injury: ____Yes ____No

Eyeglasses: ____Yes ____No

Double vision: ____Yes ____No

Glaucoma: ____Yes ____No

Allergies: ____Yes ____No

Chronic sinus trouble: ____Yes ____No

Ear disease: ____Yes ____No

Impaired hearing: ____Yes ____No

Neck

Stiffness: ____Yes ____No

Thyroid trouble: ____Yes ____No

Enlarged glands: ____Yes ____No

Respiratory

Spitting up blood: ____Yes ____No

Chronic or frequent cough: ____Yes ____No

Asthma or wheezing: ____Yes ____No

Difficulty breathing: ____Yes ____No

Neuropsychiatric

Blurring of vision: ____Yes ____No

Headache: ____Yes ____No

Psychatric problems: ____Yes ____No

Head injury/loss of consciouness: ____Yes ____No

Convulsions: ____Yes ____No

Numbness, tingling or muscle weakness: ____Yes ____No

Speech trouble: ____Yes ____No

Memory loss: ____Yes ____No

Rheumatologic

Joint pain: ____Yes ____No

Change in hand color when exposed to cold: ____Yes ____No

Back pain: ____Yes ____No

Pain in calves on walking reviewed by rest: ____Yes ____No

Pain in buttocks on walking reviewed by rest: ____Yes ____No

Genitourinary

Loss of urine: ____Yes ____No

Frequent or night time urination: ____Yes ____No

Burning or painful urination: ____Yes ____No

Blood in urine: ____Yes ____No

Kidney trouble: ____Yes ____No

Kidney stones: ____Yes ____No

Hematological

Blood disease: ____Yes ____No

Anemia: ____Yes ____No

Phlebitis or blood clots: ____Yes ____No

Abnormal bruising or bleeding: ____Yes ____No

Endocrine

Thyroid disease: ____Yes ____No

Hormone therapy: ____Yes ____No

Change in hair growth: ____Yes ____No

Gynecological (women only)

Date of last menstrual cycle:_____/_____/_____

Cycle: ___regular ___irregular ___spotting

Age when period started: _____

Menstrual pain: ____Yes ____No

Number of pregnancies: _____

Number of miscarriages: _____

Cardiovascular

Dizzy spells: ____Yes ____No

Chest pains or angina pectoris: ____Yes ____No

Shortness of breath: ____Yes ____No

Heart trouble or heart attach: ____Yes ____No

High blood pressure: ____Yes ____No

Swelling of hands, feet or ankles: ____Yes ____No

Heart murmur: ____Yes ____No

Palpitations: ____Yes ____No

Pain in calves/thighs: ____Yes ____No

If yes, is it relieved by rest? ____Yes ____No

Preventative Medicine

Last physical exam:____/____/_____

Choose One: ____Sigmoidoscopy ____Colonoscopy

Date:____/____/_____

Results: _____

Rectal exam: ____Yes ____No

Date:____/____/_____

Last eye exam:____/____/_____

Women only

Last pap/pelvic exam:____/____/_____

Last mammogram:____/____/_____

Men only

Last prostate exam:____/____/_____

PSA: :____/____/_____

Gastrointestinal

Ulcers (stomach or duodenal): ____Yes ____No

Vomiting food or blood: ____Yes ____No

Gallbladder disease: ____Yes ____No

Liver trouble: ____Yes ____No

Bleeding with bowel movement: ____Yes ____No

Reviewed by MD: _____