Tanveer Qureshi, M.D., M.D.

NAME_____ DOB_____ DATE_____

Marital Status S M W D How Long? _____ SEX: _____ RACE_____

Occupation_____ Physician/Practitioner Tanveer Qureshi, M.D.

MEDICAL HISTORY: CHECK ALL THAT APPLY

___HIGH CHOLESTEROL	___STROKE/TIA	___KIDNEY DISEASE	___BLOOD CLOTS	___BLOOD PROBLEM
___HIGH TRIGLYCERIDES	___HYPERTENSION	___PROSTATE PROBLEM	___ANEURYSM	___MENTAL DISORDER
___LOW HDL	___HEART DISEASE	___LUNG DISEASE	___ANXIETY/DEPRESSION	___OBESITY
___ASTHMA	___SEIZURES	___CANCER	___GOUT	___MENOPAUSE
___CHF	___ULCER DISEASE	___VALVE PROBLEM	___LIVER DISEASE	___ARTHRITIS
___BLOOD VESSEL PROBLEM	___HEPATITIS	___THYROID DISEASE	___OTHER	

___CARDIAC CATH DATE_____	___ECHOCARDIOGRAM DATE_____	___STRESS TEST DATE_____	___ULTRASOUND DATE_____
___HEART BYPASS SURGERY DATE_____	___BALOON ANGIOPLASTY DATE_____	___CAROTID SURGERY DATE_____	___LEG ARTERY SURGERY DATE_____
___BONE DENSITY DATE_____	___COLONOSCOPY DATE_____	___MAMMOGRAM DATE_____	___PAP SMEAR (female) DATE_____

LIST OTHER SIGNIFICANT SURGERIES AND HOSPITALIZATIONS

1.	**Date:**	**4.**	**Date:**
2.	**Date:**	**5.**	**Date:**
3.	**Date:**	**6.**	**Date:**

ALLERGIES: _____

LIST CURRENT MEDICATIONS (including supplements):

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

SOCIAL HISTORY: Do you use?

Tobacco/cigarettes now? □ yes □ no In the past? □ yes □ no How much per day? _____ How many years? _____

If you quit, how long ago? _____

Alcohol? □ yes □ no How much per day? _____ Per week? _____

Caffeine □ yes □ no How much per day? _____ Per week? _____

Recreational drugs? □ yes □ no Type_____

FAMILY HISTORY –Significant health problems or cause of death

Father _____

Mother _____

Spouse _____ Children _____

Brothers _____ Sisters_____

Other health problems occurring in blood relatives _____

_____ _____

Patient Signature Date