Karan S. Bhalla, MD, Amita S. Bhalla, MD
Andres F. Vasquez, MD, Angela B. Shiue, MD
5413 Crenshaw Rd, Suite 400 Pasadena, TX 77505
Phone (713) 943-2800 Fax (713) 943-2801

New Patient Medical History

Patient: ______________________ **Date of Birth:** ______________________

PCP: ______________________ **Pharmacy Name & Ph#** ______________________

Medical History: Check if you have any of the following:

- ☐ Asthma
- ☐ Blood clots
- ☐ Gallstones
- ☐ High Cholesterol
- ☐ Rheumatic Fever
- ☐ Angina/Chest pain
- ☐ Cancer
- ☐ Heart attack
- ☐ HIV/Aids
- ☐ Stroke
- ☐ Anemia
- ☐ Clotting disorder
- ☐ Heart Murmur
- ☐ Kidney disease
- ☐ Thyroid Disease
- ☐ Arthritis
- ☐ COPD
- ☐ Hepatitis
- ☐ Leg Swelling
- ☐ Bronchitis
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Liver disease
- ☐ Others: ______________________

Do you have a Living will? ☐ Yes ☐ No
Do you have a Power of Attorney? ☐ Yes ☐ No
If yes, who?

Family History:
☐ Diabetes ☐ Heart Attack ☐ High Blood pressure ☐ Kidney disease ☐ Stroke

Operations and/or Hospitalizations:

Reason	Date	Reason	Date

Allergies to Medication:

____

____

Habits:

Sleep? ☐ Snore ☐ Daytime drowsiness ☐ Difficulty falling asleep
Smoke? ☐ Yes ☐ No IF so, how many a day and how long? ______________________
Alcohol? ☐ Yes ☐ No If so, type, frequency and amount? ______________________
Medications? ☐ Yes ☐ No If yes, what meds? PLEASE LIST ON NEXT PAGE

Medication	Dose	Frequency	Reason