

SONU AHLUWALIA, MD

2080 CENTURY PARK EAST, SUITE 1204, LOS ANGELES, CA 90067

P: (310) 430-1310 F: (310) 870-0322

REGISTRATION FORM**PATIENT INFORMATION**

Patient's Last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status: Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Partner <input type="checkbox"/>	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		Birth date:	Age:	Social Security Number:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Preferred Language:			Race:		Ethnicity:		
Street address:			Cell phone: ()		Home phone: ()		
City:	State:	ZIP Code:	Driver's License:	Email address:			
Occupation:	Employer & Employer Address:				Employer phone: ()		
Who referred you to this office? (Please check one box):			<input type="checkbox"/> Referred by Doctor - Dr.'s Name:				
<input type="checkbox"/> Family - Name:		<input type="checkbox"/> Friend - Name:		<input type="checkbox"/> Internet		<input type="checkbox"/> Hospital - Name:	
How would you like us to contact you for appointment reminder: <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone							
PHARMACY: Name, address, and phone number of pharmacy you would like medications called in to:							

INSURANCE INFORMATION

(Please give your insurance card to the front desk.)

Person responsible for bill:	Birth date:	Address (if different):			Home phone: ()		
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this injury: <input type="checkbox"/> Work Related <input type="checkbox"/> Auto <input type="checkbox"/> Personal Injury						
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance		<input type="checkbox"/> Blue Cross	<input type="checkbox"/> Blue Shield	<input type="checkbox"/> Aetna	<input type="checkbox"/> Cigna	<input type="checkbox"/> HealthNet	
<input type="checkbox"/> SAG	<input type="checkbox"/> PacifiCare	<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicare / Medi-Cal		<input type="checkbox"/> Other		
Subscriber's name:	Subscriber's S.S. number:	Birth date:	Group number:	Policy number:	Co-payment: \$		
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other			
Name of secondary insurance (if applicable):		Subscriber's name:		Group number:	Policy number:		
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other			

IN CASE OF EMERGENCY

Name of local friend or relative :		Relationship to patient:	Home phone: ()	Work phone: ()
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Sonu Ahluwalia2, MD, Inc. or insurance company to release any information required to process my claims.				
_____ Patient/Guardian signature			_____ Date	

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HISTORY FORM - NEW PATIENT

PATIENT NAME: _____ **TODAY'S DATE** _____

Who referred you to this office? _____ **Internist/Family MD** _____

CHIEF COMPLAINT

1) What is the main reason for your visit today? _____ Right / Left /Both

HISTORY OF PRESENT ILLNESS

Age _____ Height _____ Weight _____ Right/Left Handed _____ Occupation _____

1) What was the date your symptoms started/were injured? _____

2) Explain Injury: _____

3) Was this a work related accident? Yes No
If yes, are you still working? Yes No
If yes, are you working: Full Light duty

4) Was this an auto accident? Yes No
If so, were you driving? Yes No
Did airbags inflate? Yes No

5) Recreational or athletic injury? Yes No

6) Accident in your home? Yes No

7) On a scale of 1 (least) to 10 (greatest), what level is your pain today? 1 2 3 4 5 6 7 8 9 10

8) Describe symptoms you are having (check all that apply):

- Aching Gives way Sharp Stabbing Wakes you up
- Clicking Locking Snapping Throbbing Weakness
- Dull Numbness Sore Tingling

9) How long does problem last? Constant Comes and goes Other: _____

10) Does anything make it better? Yes No Explain: _____
(eg: ice, rest, standing, sitting, meds, etc)

11) Does anything make it worse? Yes No Explain: _____
(eg: standing, sitting, bending, lifting, etc)

12) Does it radiate anywhere? Yes No If so, where: _____

13) List any other doctors you have seen for this problem: _____

14) List any previous tests, procedures, treatments (injections, physical therapy, medications) for this problem:

Physical Therapy: _____ # of visits per week x _____ weeks/months

Injections: How many? _____ Date of last injection ____/____/____ Type of injection _____

Medications you have tried: _____

Chiropractic/Acupuncture: _____ # of visits

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MEDICATIONSAre you sensitive or allergic to any medications? Yes NoIf yes, please mark all that apply: Penicillin Keflex Aspirin Codeine Tetracycline
 Erythromycin Valium Demerol Barbituates Epinephrine
 Iodine Latex Naproxen Other_____

Are you currently taking:

Any cortisone-type medication (e.g. Prednisone)? Yes NoAny blood thinning medication (e.g. Coumadin, Warfarin, ASA, Plavix, etc)? Yes NoFamily member ever had major adverse reaction to anesthesia? Yes No

If yes, Explain_____

Please list all the medications you are currently taking and the dosages:

PAST MEDICAL HISTORY

Serious Childhood Illnesses:_____

Adult Illnesses: List and document hospital stays if any_____

Surgeries: List date, procedure, surgeon, and hospital_____

Major accidents/Injuries with dates:_____

FAMILY HISTORY

Father: Age if alive_____ Age/death and cause_____

Mother: Age if alive_____ Age/death and cause_____

Siblings: Age/health status_____

Children: Age/health status_____

Family Disease: (Hypertension, Diabetes, Tuberculosis, Gout, Cancer, etc)_____

SOCIAL HISTORYDo you smoke? Yes No If yes, how much?_____ How long?_____If no, did you ever smoke? Yes No If yes, how much?_____ How long?_____ Year quit_____Do you drink alcohol? Yes No If yes, how much?_____ How often?_____Do you take any drugs? Yes No If yes, what drugs?_____

How often?_____

Have you been or are you addicted? _____ Detoxed? _____

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REVIEW OF SYSTEMS

Please circle those that apply or check the "none" box

GENERAL

Fever, Night Sweats
Marked Weight gain/loss

None

HEAD, EYES, EARS, NOSE

Frequent headaches
Neck pain/stiffness
Glaucoma
Blurring/vision
Dizziness
Hearing problems
Sinus problems

None

CHEST/RESPIRATORY

Asthma
Sputum production from cough
Cough up blood
Chronic cough
Positive TB skin test
Abnormal Chest X-ray

None

CARDIAC

High Blood Pressure
History of Heart attack
Chest Pain
Rapid/Abnormal Pulse
Ankle Swelling

None

VASCULAR

Previous phlebitis
Leg cramps on exercise
Varicose veins
Poor circulation

None

GASTROINTESTINAL

Ulcers/gastritis
Severe/frequent abdominal pain
Tarry/Black bowel movements
Yellow/Jaundice
Vomit blood, Hepatitis

None

GYNECOLOGICAL/WOMEN

Pregnant now? _____
Abnormal/irregular periods
Date last period _____
Age periods stopped _____

None

MUSCULOSKELETAL

General joint pain/arthritis
Joint swelling
Spinal pain

None

ENDOCRINE

Diabetes
Thyroid abnormality
Gout
Osteoporosis

None

NEUROLOGICAL

Fainting
Convulsions
Dizziness
Shakiness/trembling
Diffuse muscle weakness
Tingling in extremities

None

URINARY

Kidney Stones
Blood in your urine
Frequent/Painful urination
Recurrent Kidney/Bladder infections

None

PSYCHIATRIC

Psychiatric Hospitalization
Depression
Frequent Mood Swings
History of substance abuse

None

OTHER

AIDS/HIV
Tested positive for HIV? Yes No When? _____

I attest that the above information is true and correct to the best of my knowledge and recollection.

Signature of Patient or Legal Representative _____ **Date** _____