Moonat Medical Assoc Inc.
17030 Nanes Drive. Suite 211. Houston,TX 77090 Ph: (281) 440-5925 Fax: (281) 440-3324

MEDICAL HISTORY

Patient's Name _____ Sex: Male ☐ Female ☐

Date of Birth _____ Height _____ Weight _____

Referring Physician _____ Physician's Phone No. _____

Appointment with: Dr. Suresh Moonat ☐ Family Practice Dr. Saurabh Moonat ☐ Family Practice Dr. Sunita Moonat ☐ Gynecology

Reason for seeing Physician: _____

Do you have any of the following symptoms?	**Yes**	**No**		**Yes**	**No**
Headaches			Elevated Cholesterol		
Fainting Spells			Congestive Heart Failure		
Vision Changes			Heart Murmur		
Weakness/Numbness of Arms/Legs			Rheumatic Fever		
Palpitation/Irregular Heart Beat			Heart Attack		
Shortness of Breath/Wheezing			Abnormal EKG		
Cough			Diabetes		
Coughing up Blood			Thyroid Disorder		
Heartburn/Indigestion			Emphysema/Asthma		
Ankle Swelling/Fluid Retention			Pneumonia		
Need to Urinate After Bedtime			Tuberculosis		
Depression/Anxiety			Abnormal Chest X-Ray		
Have you been diagnosed to have the following condition (s)?			Gallbladder Stone		
Stroke			Bleeding in Stomach/Ulcers		
Head Injury			Hiatal Hernia		
Seizure Disorder			Hepatitis		
Chest Pain			Abdominal Aneurysm		

High Blood Pressure			Kidney Stone		
Kidney Infection			Bleeding Tendency		
Gout			Breast Nodule		
Arthritis			Other		
Lupus					
Back/Neck Pain					
Hearing Problems					

PLEASE LIST ALL HOSPITAL ADMISSIONS INCLUDING SURGERIES IN THE PAST:

Date	Hospital	Physician	Diagnosis	Surgeries

PLEASE LIST ALL MEDICATIONS INCLUDING PRESCRIBED AND OVER THE COUNTER

Medicine	Dosage	Frequency taken	Date Started	Date Stopped

PERSONAL HABITS:

Smoking: Did you ever Smoke? Yes ____ No ____ How many Packs per Day _____ How Many Years _____

Do you smoke now? Yes ____ No ____ When did you stop smoking? _____

Alcohol Use: *Current* amount of Wine, Liquor or Beer per week? _____ Any *History* of Alcohol Use? Yes ___No___

DRUG USE: Any History of Recreational Drug use? Yes ____ No ____

FAMILY HISTORY: Have you or your Family Members had any of the following diseases (If yes, then indicate their relation):

Heart Disease _____ Diabetes _____ High Blood Pressure _____ Cancer _____ Stroke _____ Asthma _____

Please check the following tests which have been done within the Past 12 Months:

Female Patients: Well Women Exam ___ Pap Smear ___ Mammogram ____ Colon Exam _____

Male Patients: Annual Physical Exam ___ Prostate Exam _____ Colon Exam _____

Patient's Signature _____ Date _____