Ranjit S. Grewal, MD
10726 Huffmeister Rd Houston, Tx 77065

Patient Medical History

Name:_____DOB:_____

How did you hear about us?_____

Pharmacy/ Location/ Phone:_____

Do you smoke: **Y N** How Much?_____ How long?_____ Do you drink alcohol? **Y N** How Much? _____

Do you have any Drug or Food Allergies?_____

Please list all medications you are currently taking:

Medication/ Dosage/ Frequency	Medication/ Dosage/ Frequency

Do you have any of the following: **Please Circle all that Apply**

Asthma	Diabetes	Anxiety	Depression	HIV	Arthritis/ Gout
Cataracts	HEP **A B C**	Stroke	Thyroid Disease	Acne	High Blood Pressure
Seizures	ADD/ ADHD	Herpes	Heart Attack	Dementia	Migraines/Headache
Anemia	Acid Reflux	High Cholesterol	Heart Murmur	Sleep Apnea	**Other (please exp.)**

Cancer if so what type:_____
Have you had any surgeries? If so please list type of Surgery and year below:

_____

Family History:

Condition	Mother	Father	Paternal Grandmother	Paternal Grandfather	Maternal Grandmother	Maternal Grandfather
Heart Disease						
Diabetes						
Stroke						
Mental Illness						
Lung disease						
Cancer (what Type)						

Please the most recent dates of the following procedures:
Mammogram:_____ Echo:_____ Spirometry:_____ Pap Smear:_____ EKG:_____ Colonoscopy:_____ Stress Test:_____

Please list any Specialist that you are currently seeing:_____

_____