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NEW PATIENT INITIAL EVALUATION

Patient Name:

Date:

Primary Phone number:

Email Address:

Family/Primary Doctor:

Primary Doctor's Phone:

Family/Primary Doctor's Address:

Who referred you to this practice? (name & address please):

INSTRUCTIONS: Please complete the following questions before you see the doctor. **Select the word or phrase that best describes your situation. You may select more than one answer per question.** Answer the question in as much detail as possible. Write additional information in the blank lines. The information you provide will help your doctor to more accurately understand your problem(s) and develop an appropriate plan of treatment for your care.

THANK YOU.

Age: Sex: Marital Status: Height: Weight:

Dominant Hand: Occupation:

What are you seeing the doctor for?

Duration of symptoms:

When did the problem first start, or when did the injury occur?

Is this injury work related?

Have you seen a doctor in past for this problem or injury?

Explain in your own words how this injury occurred:

What treatment have you had?

TELL US ABOUT YOURSELF AND YOUR PAST MEDICAL HISTORY:

Select all of the items listed below to which you are allergic:

No known allergies
Penicillin
Tetracycline
Sulfa
Morphine

Codeine
Iodine/Betadine
Radiographic Dyes
Adhesive Tape
Other (Specify):

Select all of the medical problems listed below that you have now:

I have no known medical problems
Hypertension
Coronary artery disease
Peripheral vascular disease
Adult onset diabetes
Childhood onset diabetes
Past heart attack
Asthma
Ulcers
Hepatitis A/ B / C
Cancer

Tuberculosis
Liver disease
Seizure disorder
Thyroid disease
Emphysema
COPD/ Lung disorder
Immune disorder
Overweight
Osteomyelitis
Blood Clot (DVT)
Other (Specify):

How much alcohol do you consume?

Do you now, or have you ever smoked cigarettes?

Do you now, or have you ever used the following drugs?

Recreational
Cocaine

Marijuana
Other (Specify):

Has anyone in your immediate family ever had any of the following? Select the illnesses that apply.

None known
Cancer
Leukemia
Stroke
Hypertension
Coronary artery disease
Rheumatic fever
Diabetes

Hypothyroidism
Colitis
Bleeding tendency
Asthma
Tuberculosis
Seizure disorder
Alcoholism
Other (Specify):

Have you ever had a blood clot?

Any previous broken bones:

Have you ever had a blood transfusion:

Select all surgeries listed below you may have had. Please indicate the year of surgery:

No previous surgeries
 Appendectomy
 Cataract extraction
 By-pass / open heart
 Gall bladder
 Hernia repair
 Other (Specify):

Hysterectomy
 Lumbar laminectomy
 Mastectomy
 Tonsillectomy
 Prostate surgery
 Hip/Knee surgery

What medications are you currently taking? Please include both prescription and non-prescription medications.

Medication	Dose	# Times Per Day	Medication	Dose	# Times Per Day

Please select any anti-inflammatory medications listed below which you have taken in the past. Please include all prescription and non-prescription medication and samples, which were provided.

Advil Arthrotec Daypro Ibuprofen Lodine Naprelan Naproxen
 Oruvail Tylenol Ultram Other:

Please select any of the following side effects you experienced while taking any of the above anti-inflammatory medications.

Nausea Diarrhea Gastric Ulcers Upset stomach Vomiting
 Other:

Please select any medication that you may be taking on a regular basis?

Aspirin Axid Coumadin Cytotec Heparin Maalox Mylanta
 Pepcid Prevacid Prilosec Tagamet Zantac

TELL US ABOUT YOUR HEALTH IN GENERAL: Do you have any of the following? Select YES or NO.

SYMPTOMS

COMMENTS

Chest Pain

Dizziness

Dry cough

Productive cough

Difficulty breathing

Irregular heartbeat

Swelling in the legs

Lack of appetite

Nausea

Vomiting

Diarrhea

Constipation

Abdominal cramping

Varicose veins

Bruising

Bleeding

Nose bleeds

Joint pain / stiffness

Muscle pain or cramps

Difficulty seeing

Difficulty hearing

Difficulty swallowing

Difficulty sleeping

I acknowledge that everything I have answered is true and correct to the best of my knowledge and understand that this will become a part of my permanent medical record.

Patient Signature

**THANK YOU FOR COMPLETING THIS PATIENT QUESTIONNAIRE.
THIS FORM WILL BECOME A PART OF YOUR PERMANENT MEDICAL RECORD.**