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NEW PATIENT INITIAL EVALUATION

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Family/Primary Doctor: \_\_\_\_\_ 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. **Check 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: Male Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Marital Status: Single Married Widowed Handed: Right Handed Left Handed

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? Yes No

Have you seen a doctor in past for this problem or injury? Yes No If yes, who and when?

Explain in your own words how this injury occurred:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What treatment have you had?  
\_\_\_\_\_  
\_\_\_\_\_

**TELL US ABOUT YOURSELF AND YOUR PAST MEDICAL HISTORY:**

Check mark anything listed below to which you are allergic:

No known allergies  
Penicillin  
Tetracycline  
Sulfa  
Morphine  
Erythromycin

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

Check mark any 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?

I'm a non-drinker  
I'm a recovering alcoholic  
I drink only occasionally  
I drink weekends only

An average of 1-2 drinks per day  
An average of 2-3 drinks per day  
An average of 3-4 drinks per day  
More than 6 drinks per day

Do you now, or have you ever smoked cigarettes?

Yes, I am currently a smoker. I smoke \_\_\_\_\_ packs a day  
I have smoked for \_\_\_\_\_ years  
No, but I used to smoke I smoked for \_\_\_\_\_ years  
No, I have never smoked

Do you now, or have you ever used drugs?

Recreational  
Cocaine  
Marijuana  
Other (Specify): \_\_\_\_\_

Has anyone in your immediate family ever had any of the following? Circle 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?                      Yes                      No

Check mark any surgeries listed below you may have had. Indicate the year of surgery:

No previous surgeries _____	Hysterectomy _____
Appendectomy _____	Lumbar laminectomy _____
Cataract extraction _____	Mastectomy _____
By-pass / open heart _____	Tonsillectomy _____
Gall bladder _____	Prostate surgery _____
Hernia repair _____	Hip/Knee surgery _____
Other (Specify): _____	

Any previous broken bones: \_\_\_\_\_

Blood transfusion:                      Yes                      No                      Year: \_\_\_\_\_

**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 check mark 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 check mark 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 check mark the medication below if you are currently taking any of them 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? Check mark YES or NO.

SYMPTOMS

COMMENTS

Chest Pain	Yes	No	_____
Dizziness	Yes	No	_____
Dry cough	Yes	No	_____
Productive cough	Yes	No	_____
Difficulty breathing	Yes	No	_____
Irregular heartbeat	Yes	No	_____
Swelling in the legs	Yes	No	_____
Lack of appetite	Yes	No	_____
Nausea	Yes	No	_____
Vomiting	Yes	No	_____
Diarrhea	Yes	No	_____
Constipation	Yes	No	_____
Abdominal cramping	Yes	No	_____
Varicose veins	Yes	No	_____
Bruising	Yes	No	_____
Bleeding	Yes	No	_____
Nose bleeds	Yes	No	_____
Joint pain / stiffness	Yes	No	_____
Muscle pain or cramps	Yes	No	_____
Difficulty seeing	Yes	No	_____
Difficulty hearing	Yes	No	_____
Difficulty swallowing	Yes	No	_____
Difficulty sleeping	Yes	No	_____

**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.**