Duraid Ahad-Daman M.D
1380 Coolidge Hwy Suite 250
Troy, Mi 48084

Patient History Form

Name: _____ **Date of birth: _____** **Date: _____**

Eyes		**Hematologic/Lymphatic**	
Double Vision	Yes/No	Swollen Glands	Yes/No
Glaucoma	Yes/No	Blood Clotting Problems	Yes/No
Cataracts	Yes/No	Tired/Sluggish	Yes/No
Ear/Nose/Throat/Mouth		**Cardiovascular**	
Hearing Changes	Yes/No	Chest Pain	Yes/No
Sore Throat	Yes/No	Irregular Heartbeat	Yes/No
Sinus Problems	Yes/No	Swelling in Ankles	Yes/No
		Leg pain upon walking	Yes/No

Psychological		**Endocrine**	
Are you generally happy?	Yes/No	Excessive Thirst	Yes/No
Do you feel depressed?	Yes/No	Too hot/Cold	Yes/No
Do you feel anxious?	Yes/No	Tired/Sluggish	Yes/No
Do you feel safe?	Yes/No		
Genitourinary		**Musculoskeletal**	
Change in steam	Yes/No	Bone Pain	Yes/No
Urine Frequency	Yes/No	Muscle pain	Yes/No
Urinary Urgency	Yes/No	Joint Pain	Yes/No

Constitutional Symptoms		**Sexual History**	
Weight Change	Yes/No	Change in Sex drive	Yes/No
Chills	Yes/No	Sexual Performs Satisfactory	Yes/No
Sleep Disorder	Yes/No	History of STD's	yes/No
Integumentary		**Neurological**	
Rash	Yes/No	Tremors	Yes/No
Lumps/ Bumps	Yes/No	Dizzy Spells	Yes/No
Moles/Skin tags	Yes/No	Numbness/ Tingling	Yes/No
Respiratory		**Gastrointestinal**	
Wheezing	Yes/No	Abdominal pain	Yes/No
Frequent Cough	Yes/No	Nausea/Vomiting	Yes/No
Shortness of breath	Yes/No	Indigestion/heartburn	Yes/No

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Medical/ Surgical History

_____

_____

_____

Social History

Are you a smoker? Yes/No/Previous If yes, how much? __ # of packs a day. How many years? __
Do you drink? Yes/No/Previous If yes, how much? _____
Do you Exercise? Yes/No If yes, What and how frequent? _____

Family History

Father: Living? ___ Age? ____ Deceased, Age of death ___ (Cause) _____
Mother: Living? ___ Age? ____ Deceased, Age of death ___ (Cause) _____
Siblings: Number Living? _____ Number Deceased? ___ (Cause) _____

List any family illnesses:

_____

_____

Allergies? (Medications/Food)

_____

_____

Current Prescription/ Over the Counter Medications?

_____

_____

Previous Exams? (Dates Requested)

Eye? _____ Tetanus shot? _____

Dental? _____ Pap Smear? _____