



DR. AZIZ Clinic

7320 East 82nd Street, Indianapolis, Indiana 46256
 317-842-5771, Fax 317-576-1394, 800-745-6615

Office Use Only
Data entered by: _____
Today's date

Patient Data Sheet

Patient Information							
Last Name		First Name		Middle Initial		Male <input type="radio"/>	Female <input type="radio"/>
Address Street			Address City		Address State		ZIP Code
Phone (Primary)		Phone (Other)		Email Address			
Date of Birth		Social Security #		Referred by:			
Height	Weight	Do you smoke? Y or N		Are you pregnant? Y or N If yes, when is your due date? _____ Are you planning to become pregnant? Y or N			
Allergies and Adverse Reactions: (Use corresponding codes as listed below) R = Rash DB = Difficulty Breathing SU = Stomach Upset or O = Other							
<input type="checkbox"/>	No known drug allergies		<input type="checkbox"/>	Erythromycins		<input type="checkbox"/>	Peanuts
<input type="checkbox"/>	Aspirin		<input type="checkbox"/>	Iodine		<input type="checkbox"/>	Penicillins
<input type="checkbox"/>	Benzodiazepines		<input type="checkbox"/>	I.V. contrast dyes		<input type="checkbox"/>	Sulfa drugs
<input type="checkbox"/>	Cephalosporins		<input type="checkbox"/>	Latex		<input type="checkbox"/>	Tetracycline
<input type="checkbox"/>	Codeine		<input type="checkbox"/>	Morphine		<input type="checkbox"/>	Other: _____
Illnesses and Other Conditions (Check All that Apply)							
Personal History	Family History			Personal History	Family History		
<input type="checkbox"/>	<input type="checkbox"/>	No known medical conditions		<input type="checkbox"/>	<input type="checkbox"/>	Heart disease (429.9)	
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal disorders		<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	
<input type="checkbox"/>	<input type="checkbox"/>	Anemia (285)		<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma (493)		<input type="checkbox"/>	<input type="checkbox"/>	Infertility	
<input type="checkbox"/>	<input type="checkbox"/>	Cancer (type) _____		<input type="checkbox"/>	<input type="checkbox"/>	Joint disorder	
<input type="checkbox"/>	<input type="checkbox"/>	Birth control pills for contraception		<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	
<input type="checkbox"/>	<input type="checkbox"/>	Blood clotting disorder		<input type="checkbox"/>	<input type="checkbox"/>	Lung problems (type) _____	
<input type="checkbox"/>	<input type="checkbox"/>	Breastfeeding		<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	
<input type="checkbox"/>	<input type="checkbox"/>	Depression		<input type="checkbox"/>	<input type="checkbox"/>	Mouth or throat problems	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes—insulin dependent (250)		<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal disease	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes—non-insulin dependent (250.0)		<input type="checkbox"/>	<input type="checkbox"/>	Neck disorder	
<input type="checkbox"/>	<input type="checkbox"/>	Ear disorder		<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorder	
<input type="checkbox"/>	<input type="checkbox"/>	Esophageal ulcer		<input type="checkbox"/>	<input type="checkbox"/>	Peptic ulcer disease (533)	
<input type="checkbox"/>	<input type="checkbox"/>	Eye disorder		<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy (646.9)	
<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary disorder		<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma (365)		<input type="checkbox"/>	<input type="checkbox"/>	Stomach ulcer (531.9)	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches/migraines (784.0/346)		<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease (246.9)	
Primary Care Physician							
Name _____			Phone (____) _____			Fax (____) _____	

