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Patient Name: _____

Date: _____

Date of Birth: _____

Family History

Cancer: No Yes Who: _____ Type of Cancer: _____

Heart Disease: No Yes Who: _____ Dementia: No Yes Who: _____

Stroke: No Yes Who: _____ Depression/ Suicide: No Yes Who: _____

Diabetes: No Yes Who: _____ High Cholesterol: No Yes Who: _____

Hypertension: No Yes Who: _____

Other Conditions: _____ Who: _____

Habits:

Tobacco Use: Never smoked Current Smoker, PPD: ____ Current Chew up/ Dip Use

Previous Smoker, How many years: ____ Year quit: ____

Alcohol Use: No Yes Amount: ____ per week Alcohol usage a concern for others: No Yes

Recreational Drugs: No Yes

Social History:

Marital Status: Single Married Divorced Widowed

Children: No Yes Boy/Girl Age: ____ Boy/Girl Age: ____ Boy/Girl Age: ____

Lives: Alone Spouse Family Institutional Other: _____

Highest Level of Education: High School Undergrad Grad School Other: _____

Occupation: _____

Exercise: No Yes Current Physical Activity compared to last year: More Less Same as last year

Ambulatory Status: Independent Cane Walker Wheelchair Bedbound

Past Surgical History (Surgeries/Hospitalizations):

Sign: _____ Date: _____