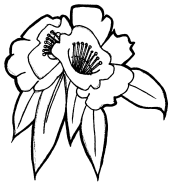
Pratistha Strong, D.O.
Kathmandu Clinic
111 Prospect Ave., Ste 202D
Kirkwood, MO 63122



918-814-3996
pratistha.strong@gmail.com
www.DoctorPStrong..com

Name:_____ Date:_____

Patient Profile
Patient Name:_____ DOB:_____

Address:_____City:_____State:_____ Zip:_____

Phone# (H):_____(W):_____ Other:_____

Email: _____
May Dr. Strong to leave medical information on your answering machine/voicemail? YES NO
May Dr. Strong to send medical information in your email? YES NO
May Dr. Strong to send medical information in your text messages? YES NO

Spouse/Significant Other:_____

Children's names and ages:_____

Patient Employer:_____ Address:_____

Responsible Party (complete if different than patient)
Name:_____ DOB:_____
Address:_____City:_____State:_____ Zip:_____
Phone# (H):_____(W):_____ Other:_____
Employer:_____Address:_____

Emergency Contact
Name:_____Phone:_____
Address:_____ Relationship:_____

Preferred Pharmacy Name/Address:_____
Number/Fax: _____

Please list names: include physical therapy, psychology, acupuncture, massage, diet, chiropractor:
Your Health Care Provider:_____
Address: _____
Number/Fax: _____

Your Health Care Provider:_____
Address: _____
Number/Fax: _____

Your Health Care Provider(s):_____
Address: _____
Number/Fax: _____

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Name:_____ Date:_____

Health Information

Current Medications (Include all prescriptions and over the counter drugs, supplements, herbals)

☐ **NO CURRENT MEDICATIONS**

Medication Name	**Dosage Amount** (Ex. 15 mg, 2 puffs, 5 meq)	**Take** (Ex. 1 tablet, 2 tablets 1 to 2 tablets)	**Frequency** (Ex. Once a day, Twice a day, as needed)	**Reason for Medication** (Ex. High blood pressure, diabetes, high cholesterol)

Medication Allergies: (List Reactions or write unknown): ☐ **NO KNOWN DRUG ALLERGIES**

_____

_____

Past (or Current) Medical History (circle all that apply):

Acne	Depression	Headaches	Impotence	Rosacea
Anxiety	Diabetes	Heart Attack	Infertility	Seasonal Allergies
Asthma	Eczema	Heart Disease	Migraines	Seizures
Bleeding Disorders	Emphysema	Heart Murmur	Mitral Valve Prolapse	Sleep Disorder
Cancer_____	Erectile Dysfunction	Hemorrhoids	Nerve Damage	Stomach
Cirrhosis	Fibromyalgia	Hepatitis	Psoriasis	Stroke
Concussion	Gallstones	High Blood Pressure	Prostate	Thyroid Disease
COPD	Glaucoma / Cataracts	HIV / AIDS	Rheumatic Fever	Tuberculosis
				Ulcers
				Venereal Diseases

Other: _____

Psychiatric History:

Have you ever been treated for emotional problems? Yes or No
Have you ever considered attempted suicide? Yes or No

Men's History:

Diagnosed with prostate cancer? (date of diagnosis):_____
Urinary issues?(increased frequency/not emptying/night time): _____
_____
PSA level / date:_____
Erectile dysfunction?_____
STD checked /date?_____

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Name:_____ Date:_____

GYN History:
First day of LMP_____ Age at first menstrual period _____
# of days between periods: _____ Length of periods: _____
Age at menopause: _____

Method of birth control: ☐Condoms ☐Oral Contraceptive ☐IUD ☐Shot ☐None ☐Other: _____

Date of last PAP: _____ Results: Normal or Abnormal
History of abnormal PAP? Yes or No Treatment (if any): _____

Do you do self-breast exams? Yes or No Have you ever found a lump? Yes or No

Sexual dysfunction?_____

OB History: Total # of pregnancies: _____ Total # full term deliveries: _____
Total # of preterm deliveries: _____ Total # of miscarriage(s): _____
Total # of abortions: _____ Total # of ectopic pregnancies:_____
Total # of multiple birth(s): _____

Surgeries: (include all dates): _____
Have you been **hospitalized** for anything besides surgery? _____

Accidents/Traumas: (include all dates): _____

Family History: Please list if your **mom, dad, brothers, sisters, children**, have had any of the following? If any of these individuals have passed away, please write age at death and reason.

Asthma:

Cancer: (which type)

Diabetes:

Depression or suicide:

Heart problems:

High blood pressure:

High cholesterol:

Thyroid problems:

Stroke:

Other illness:

# of Siblings: Brothers_____ Sisters_____ ☐Healthy

# of Children: Sons_____ Daughters _____ ☐Healthy

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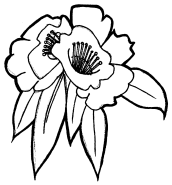

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Name:_____ Date:_____

Social History:
What level of education did you finish? _____
Any barriers to learning?
☐ Language ☐ Culture ☐ Hearing ☐ Vision ☐ Permanent Cognitive Impairment ☐ None

Do you use tobacco? Yes or No What type?_____ Amount?_____
How many years of tobacco use?_____ Quit date:_____

Do you drink alcohol? Yes or No Quit date:_____
If yes, how often did you have 5 or more drinks (as a man) or 4 or more drinks (as a woman) on one occasion in the past year? ☐1 or more ☐ Daily ☐Weekly ☐Monthly ☐Never

Do you use illicit drugs? Yes or No What type?_____Quit date:_____

Caffeine intake: ☐ Coffee ☐ Soda ☐Tea ☐ Energy Drink ☐None **How often? _____**

Exercise regularly? Yes or No How many times per week? _____ Type: _____
Do you always wear a seatbelt in the car?_____
Do you have firearms in your home?_____ locked/unloaded?_____

Do you have problems with sleep? Please elaborate if you wish.
_____
Do you have problems with stress? Please elaborate if you wish.
_____
Special diets? _____ Reason? _____
What is your typical diet consist of in a 24 hour period? (Breakfast, lunch, dinner. Oils you cook with; fast food frequency; frequency of home cooked meals; water intake)

_____
Are you in pain? Please elaborate if you wish.
_____

Sexual History: (Leave any questions blank if you are uncomfortable answering them. Feel free to discuss any concerns with Dr. Strong.)
Have you ever had sexual intercourse? Yes or No If yes, the following will apply:

Are you currently sexually active? Yes or No

Have your sexual partners been: Men or Women or Both

What was your age at first intercourse? _____

Total number of lifetime partners:_____Number of lifetime partners in the last 12 months: _____

Have you had intercourse without contraception since your last menstrual period? Yes or No

Have you had intercourse without a condom since your last STD testing? Yes or No

Does your partner have any symptoms of infection? Yes or No

Have you experienced any unwanted sexual encounters? Yes or No

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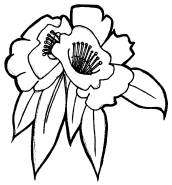

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Name:_____ Date:_____

Health Maintenance:
Eye exam: When was your last exam? _____
Dental exam: When was your last exam? _____
Hearing exam: When was your last exam? _____
Immunizations up to date? Yes or No Reason if No:_____

Flu Vaccination (ALL AGES): When was your last flu shot? _____
Tetanus within 10 years? Yes or No
Hepatitis B series? Yes or No
Gardasil (HPV)? Yes or No
Pneumonia Vaccine (65 YEARS AND OLDER)

Have you had a pneumonia vaccine? YES or NO
If yes, where/when was your last Pneumonia vaccination? _____

Colonoscopy (IF YOU ARE BETWEEN THE AGES 50 - 75 YEARS OLD)

Have you ever had a colonoscopy? YES or NO
If yes, when/where/results? _____
If no, would you be interested in having one? YES NO

Mammogram (IF YOU ARE A WOMAN BETWEEN 50 – 75 YEARS OLD)
When/where was your last mammogram? _____
Results of last mammogram? _____

DEXA (IF YOU HAVE HAD ONE IN THE LAST 2 YEARS)
Have you ever had a DEXA? YES or NO
If yes, When/Where was your last DEXA? _____

What are your health goals?

What is your life purpose?

Anything else you wish to share?