**Mala Bathija MD, PLLC**

44000 West 12 Mile Road, Suite 212
Novi, MI 48377

14500 Northline Road
Southgate,MI 48195

# NEW PATIENT QUESTIONNAIRE

Last Name_____ First Name_____
Phone #_____ DOB_____ Age_____ Sex: M F
Referring Physician_____
Referring Physician Address_____
_____Today's date _____

**Reason for today's visit:**

_____
_____
_____
_____

**Past Medical History (please mark all that apply)**

| | |
|---|---|
| ☐ | **Allergies/Hayfever** |
| ☐ | **Anemia** |
| ☐ | **Aneurysm** |
| ☐ | **Ankles-swollen (Circle: one/both)** |
| ☐ | **Arthritis** |
| ☐ | **Asthma/Wheezing** |
| ☐ | **Back pain** |
| ☐ | **Bleeding tendency/bruise easily** |
| ☐ | **Blood clots** |
| ☐ | **Bone fractures** |
| ☐ | **Broken ribs** |
| ☐ | **Bronchitis** |
| ☐ | **Cancer (type):** |
| ☐ | **Cataracts** |
| ☐ | **Chest injury** |
| ☐ | **Chickenpox** |
| ☐ | **Collapsed lung** |
| ☐ | **Convulsions/Seizures** |
| ☐ | **COPD/Emphysema/Chronic Bronchitis** |
| ☐ | **Cystic Fibrosis** |
| ☐ | **Depression** |
| ☐ | **Diabetes** |
| ☐ | **Difficulty swallowing** |
| ☐ | **Eczema** |
| ☐ | **Fatigue-chronic** |
| ☐ | **Glaucoma** |
| ☐ | **Heart Attack** |
| ☐ | **Heartburn/Reflux** |
| ☐ | **Heart Failure** |
| ☐ | **Heart valve problems** |
| ☐ | **Hepatitis/liver disease** |
| ☐ | **Herpes** |
| ☐ | **High Blood pressure** |
| ☐ | **High cholesterol** |
| ☐ | **HIV positive or AIDS** |
| ☐ | **Hives** |
| ☐ | **Insomnia** |
| ☐ | **Irregular heartbeat** |
| ☐ | **Jaundice (yellow skin/eyes)** |
| ☐ | **Kidney disease** |
| ☐ | **Lupus** |
| ☐ | **Meningitis/brain infection** |
| ☐ | **Migraine headaches** |
| ☐ | **Neurological problems** |
| ☐ | **Nose Bleeds** |
| ☐ | **Nasal or Sinus polyps** |
| ☐ | **Osteoporosis** |
| ☐ | **Pleural fluid/effusion** |
| ☐ | **Pneumonia** |
| ☐ | **Prematurity** |
| ☐ | **Prostate problems** |
| ☐ | **Psychiatric problems** |
| ☐ | **Recurring infections** |
| ☐ | **Rheumatoid arthritis** |
| ☐ | **Sexually transmitted disease** |
| ☐ | **Sinus infections** |
| ☐ | **Sleep apnea** |
| ☐ | **Skin infections** |
| ☐ | **Stomach or esophageal ulcers** |
| ☐ | **Stroke** |
| ☐ | **Thyroid disease** |
| ☐ | **Tuberculosis (TB)** |
| ☐ | **Varicose veins** |

**Have you ever been on a ventilator (life support machine)** **Yes** **No**
**If yes, when and for what?**

_____

_____

**Do you have any other conditions requiring regular medical attention that we should be aware of?**

_____
_____
_____
_____

Patient Name_____ DOB _____Today's date_____

**Past Surgical History (Please list all surgeries since birth)**

| Surgery | Year | Surgery | Year |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Are you allergic to any foods? Please list food with reaction.**

| Food | Reaction | Food | Reaction |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Are you allergic to any medications? Please list medication with reaction.**

| Medication | Reaction | Medication | Reaction |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Are you allergic to latex? Please describe reaction.**

_____

_____

**Have you had an allergic reaction to an insect sting? Please describe.**_____

_____

**Have you ever had poison ivy or a skin reaction to metals or plants? Please describe.**

_____

_____

**Please list all medications that you take with their doses. PLEASE INCLUDE HERBAL REMEDIES, VITAMIN SUPPLEMENTS, OVER THE COUNTER MEDICATIONS, EYE DROPS AND CREAMS.**

_____

_____

Patient Name _____DOB_____Today's date _____

**Family Medical History: Please check all that apply.**

| Illness | Father | Mother | Sister | Brother | Children | Other relative |
|---|---|---|---|---|---|---|
| **Allergies/Hayfever** | | | | | | |
| **Angioedema (swelling)** | | | | | | |
| **Arthritis** | | | | | | |
| **Asthma** | | | | | | |
| **Bleeding Disorder** | | | | | | |
| **Blood Clots** | | | | | | |
| **Cancer** | | | | | | |
| **Cystic fibrosis** | | | | | | |
| **Diabetes** | | | | | | |
| **Eczema** | | | | | | |
| **Heart Disease** | | | | | | |
| **High Blood Pressure** | | | | | | |
| **Hives** | | | | | | |
| **Immunodeficiency (recurrent infection)** | | | | | | |
| **Interstitial lung disease** | | | | | | |
| **Kidney disease** | | | | | | |
| **Lupus** | | | | | | |
| **Pulmonary fibrosis** | | | | | | |
| **Rheumatoid arthritis** | | | | | | |
| **Sickle cell** | | | | | | |
| **Stroke** | | | | | | |

**Review of Systems: Please check if you have any of the following symptoms**

**General:** □ Fever □ Chills □ Sweats □ Fatigue □ Snoring □ Dayttime sleepiness □ Weight change

_____

**Skin:** □ Rash □ Color change □ Hives □ Rash in sun

_____

**Blood:** □ Bruise easily □ Bleeding □ low blood count □ Swollen glands

_____

**Endo:** □ Cold/ heat intolerance □ steroid therapy_____

**Eye:** □ Blindness □ Pain □ Cataracts □ light sensitivity □ Vision changes_____

**ENT:** □ Nosebleeds □ Mouth/ tongue sores □ dentures □ Neck Mass

_____

**CV:** □ Murmur □ Irregular heartbeat □ Fainting □ leg swelling □shortness of breath when lying flat □ chest pain

_____

**Resp:** □ Cough □ shortness of breath □ sputum □ retractions

_____

**GI:** □ Vomiting □ Belly Pain □ blood in stools □ diarr hea □ constipation □ heartburn □ difficulty swallowing

_____

**GU:** □ Pain with urination □ blood in urine_____

**Musc:** □ Arthritis □ morning stiffness □ joint swelling □ muscle ache _____

**Neuro/Psych:** □ numbness/tingling □ weakness □ depression □ anxiety □ suicidal ideation

_____

44000 West 12 Mile Road, Suite 212
Novi, MI 48377
Phone: (248) 347-8285
Fax: (248) 347-8215

14500 Northline Road
Southgate, MI 48195
Phone: (734) 281 – 4197
Fax: (734) 282 - 0093

# Mala Bathija, MD

Allergy, Asthma & Immunology

## Patient Information

Patient Last Name _____ First Name_____ MI _____

Home Address_____ Home Phone _____

City & State _____ Zip _____Work Phone _____

Patient date of birth _____ Patient Sex (circle) M F Patient SS# _____

Patient Employer _____ Occupation _____

Referring Physician _____ Referring Physician Phone _____

Nearest relative not living with you _____

Relationship _____ Phone _____

Who is financially responsible for the bill _____

## Primary Insurance Information

Insurance Company _____

Policy holder name _____ Policy holder SS# _____

Address if different from above _____

Policy holder's date of birth _____ Employer Name _____

Patient relationship to policyholder (please check) Self _____ Spouse _____ Dependent _____ Other _____

## Secondary Insurance Information

Is there a secondary insurance company? _____ Insurance company _____

Policy holder name _____ Policy holder SS# _____

Address if different from above _____

Policy holder's date of birth _____ Employer Name _____

Patient relationship to policyholder (please check) Self _____ Spouse _____ Dependent _____ Other _____

Allergies to any medications? _____

ALL COPAYS ARE PAYABLE AT THE TIME OF SERVICE.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any service rendered. I am responsible for obtaining any referrals for treatment and agree to be responsible for any costs if my referral is denied for any reason. I authorize direct payment of medical and benefits to Malathi Bathija MD. I authorize release of information necessary to process any insurance claims submitted by Malathi Bathija MD.

_____

Patient or Guardian signature Relationship to patient Date