Arlington Gastroenterology Services Hamid Kamran, MD, PA

HISTORY & PHYSICAL PATIENT INFORMATION

NAME:	DATE:		
WEIGHT:pounds	HEIGHT:	feet inches	
	rienced the following? Check Yes (Y) or No (N)	
Y N Abnormal Bleeding Artificial Valves Chemotherapy Bifficulty Breathing Heart Murmur Giran HIV / AIDS Glaucoma Giran Hospitalized Mitral Valve Prolapse Artificial Bones/Joints Epilepsy Liver Disease Ulcers or Stomach Disease	Y N Low Blood Pressure Rheumatic Fever Stroke Alcohol Abuse Asthma Colitis Drug Abuse Heart Surgery Pacemaker Seizures Cancer Heart Attack Radiation Treatment	Y N Scarlet Fever Thyroid Problems Arthritis Blood Transfusion Congenital Heart Disea Headaches Hepatitis Kidney Problems Tuberculosis (TB) Diabetes High Blood Pressure Sinus Problems Chest Pain After Exerc	
Please list names of medications y	ou are currently taking:		
Please list any drug allergies:			
☐ Acetaminophen ☐ Antibiotics ☐ Antihistamines ☐ Aspirin ☐ Blood Thinners ☐ Vitamins	g? Check Yes (Y) or No (N) Y N I Blood Pressure Medication Cold Remedies I Digital/Heart Medication Insulin/Diabetes Medication Insulin/Diabetes Medication Insulin/Diabetes Medication Insulin/Diabetes Medication	Y N ☐ Recreational Drugs ☐ Steroids/Cortisone ☐ Thyroid Medicine ☐ Tranquilizers ☐ Antidepressant y?	