BASSI CLINIC
YOUR HEALTH.OUR PRIORITY

11110 N Tatum Blvd., Ste 103, Phoenix, AZ 85028
Phone: 602.354.3311 • Fax: 602.354.3751

Patient Name: _____ Date of Birth: _____ Date: _____

Welcome to Bassi Clinic. Please fill out this form entirely and as accurately as possible. This information will help Dr. Bassi determine the best possible care for you. All information will be kept strictly confidential.

	*YES	NO
Do you have a **Living Will**?	☐	☐
Do you have an **Advance Directives**?	☐	☐
Do you have **Medical Power of Attorney**?	☐	☐

*If yes, please provide a copy for our records.

Main reason for your visit today (Chief complaint):

_____
_____
_____
_____

Allergies: ☐ Yes ☐ No known drug allergies.
If yes, please specify:

	Medication	Adverse Reaction
1.	_____	
2.	_____	
3.	_____	
4.	_____	
5.	_____	
6.	_____	

Non-drug or Food allergies, if any:

_____

Medications:
(Prescriptions, Supplements, Herbals and Over the Counter)

	Name	Dose and Frequency
1.	_____	
2.	_____	
3.	_____	
4.	_____	
5.	_____	
6.	_____	
7.	_____	
8.	_____	

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Personal Medical History:

	YES	NO
Acid reflux	☐	☐
Anemia	☐	☐
Aneurysm	☐	☐
Anxiety disorder	☐	☐
Arrhythmia	☐	☐
Asthma	☐	☐
Arthritis	☐	☐
Atrial fibrillation	☐	☐
Bleeding disorder	☐	☐
Blood disorder	☐	☐
Cancer _____	☐	☐
Celiac disease	☐	☐
Cirrhosis	☐	☐
Chronic bronchitis	☐	☐
Congestive heart failure	☐	☐
Constipation	☐	☐
COPD	☐	☐
Coronary artery disease	☐	☐
DVT	☐	☐
Dementia	☐	☐
Depression	☐	☐
Diabetes mellitus Type _____	☐	☐
Diverticulosis/Diverticulitis	☐	☐
Eating disorder	☐	☐
Emphysema	☐	☐
Erectile dysfunction	☐	☐
Fibromyalgia	☐	☐
Gallstones	☐	☐
Glaucoma	☐	☐
Gout	☐	☐
Heart attack/MI	☐	☐
Hepatitis A/B/C	☐	☐
Hemorrhoids	☐	☐
High blood pressure	☐	☐
High Cholesterol	☐	☐
HIV/AIDS	☐	☐

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	YES	NO
Irritable Bowel Syndrome	☐	☐
Jaundice	☐	☐
Kidney problems/Failure/stones	☐	☐
Liver disease	☐	☐
Lupus	☐	☐
Migraine	☐	☐
Mini stroke/TIA	☐	☐
Murmurs	☐	☐
Osteopenia/Osteoporosis	☐	☐
Pacemaker	☐	☐
Pancreatitis	☐	☐
Parkinson's	☐	☐
Pneumonia	☐	☐
Polycystic Ovary Syndrome	☐	☐
Positive TB test	☐	☐
Prostate problems	☐	☐
Pulmonary embolism	☐	☐
Pulmonary Hypertension	☐	☐
Restless leg syndrome	☐	☐
Recurrent UTI	☐	☐
Rheumatic fever	☐	☐
Rheumatoid arthritis	☐	☐
Sarcoidosis	☐	☐
Seasonal allergies	☐	☐
Seizure disorder	☐	☐
Sinusitis	☐	☐
Skin problems	☐	☐
Sleep apnea	☐	☐
Stomach ulcers	☐	☐
Stroke	☐	☐
STD	☐	☐
Thyroid problems	☐	☐
Tuberculosis	☐	☐
Ulcerative colitis	☐	☐
Valley fever	☐	☐

Other medical conditions: _____

_____

_____

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Surgical History:
(Please list any surgeries you have had in past with approximate dates)
_____
_____
_____

Any past hospitalizations:
(Please list dates, name of hospital and reason for hospitalization)
_____
_____
_____
_____

Family History:
Father: _____
Mother: _____
Siblings: _____
Children: _____
Blood relatives: _____

Social History:
Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed
Children: _____ Boys: ____ Girls: ____
Employed: □ No □ Yes. If yes, Occupation: _____
Smoking: □ No □ Yes. If yes, how many: _____ Since when: _____
If quit, when: _____
Alcohol: □ No □ Yes. If yes, how much: _____
Recreational Drugs: □ No □ Yes. If yes, Names: _____

Spiritual History:
Do you have a religious preference: □ No □ Yes. If yes: _____
Describe your sleep: □ Disturbed □ Uninterrupted, Hours: _____
What relaxes you: _____
Do you meditate or use other relaxation technique? _____
Have you tried any Alternative/Complimentary therapy? _____

Physical Activity: Type: _____
Duration: _____
Frequency: _____
Intensity: _____

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Patient Name: _____ Date of Birth: _____ Date: _____

Sexual History:
Are you sexually active? □ No □ Yes
Do you practice safe sex? □ Yes □ No □ Decline
Do you use birth control? □ No □ Yes, type: _____

Pregnancy History:
Are you currently pregnant? □ No □ Yes, Due date: _____
Number of pregnancies___ Live births___ Abortions ___ Miscarriages ___

Immunization History:
(Please provide dates taken if possible)

Tetanus: _____
Pneumonia: _____
Flu shot: _____
Hepatitis: _____
Other: _____

Other Providers you see:

	Name	Specialty	Phone Number
1.			
2.			
3.			
4.			
5.			
6.			

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Patient Name: _____ Date of Birth: _____ Date: _____

Review of Systems:

General:	**YES**	**NO**
Fever	☐	☐
Unusual tiredness	☐	☐
Unexplained weight loss/gain	☐	☐
Sleep disturbance	☐	☐
Head:		
Headaches	☐	☐
Fainting spells	☐	☐
Dizziness	☐	☐
Seizures	☐	☐
Eyes:		
Blurred, Double or loss of vision	☐	☐
Red eye	☐	☐
Eye pain	☐	☐
Ear, Nose, & Throat:		
Hearing loss	☐	☐
Ringing in ears	☐	☐
Frequent infections	☐	☐
Ear pain	☐	☐
Nasal congestion	☐	☐
Nose bleeds	☐	☐
Sore throat	☐	☐
Neck:		
Mass or swollen glands	☐	☐
Goiter	☐	☐
Pain/Stiffness	☐	☐
Hormonal:		
Excessive thirst	☐	☐
Excessive sweating	☐	☐
Excessive hunger	☐	☐

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Respiratory:	**YES**	**NO**
Shortness of breath	☐	☐
Dry cough	☐	☐
Cough with phlegm	☐	☐
Wheezing	☐	☐

Cardiac:		
Chest pain at rest	☐	☐
Chest pain with exertion	☐	☐
Palpitations	☐	☐
Ankle/Leg swelling	☐	☐

Gastrointestinal:		
Abdominal pain	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Vomiting blood	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Blood in stool	☐	☐
Dark stool	☐	☐
Heartburn	☐	☐

Date of last colonoscopy _____ Result _____

Genitourinary:		
Blood in urine	☐	☐
Pain or Burning on urination	☐	☐
Frequent urination	☐	☐
Urgency of urination	☐	☐
Hesitancy	☐	☐
Difficulty urinating	☐	☐
Urinary leakage	☐	☐

Musculoskeletal:		
Joint pain	☐	☐
Back pain	☐	☐
Joint swelling	☐	☐

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Vascular:	**YES**	**NO**
Cold hands or feet	☐	☐
Leg pain on walking or at rest	☐	☐
Skin:		
Rash	☐	☐
Moles	☐	☐
Discoloration	☐	☐
Breasts:		
Lump	☐	☐
Pain	☐	☐
Nipple discharge	☐	☐
Women only:		
Irregular menses	☐	☐
Heavy menses	☐	☐
Painful intercourse	☐	☐
Vaginal discharge	☐	☐
Using birth control	☐	☐
On Hormone replacement	☐	☐
Last Pap done on _____		
History of abnormal Pap	☐	☐
History of abnormal Mammogram	☐	☐
Last Menstrual period _____		
Neurological:		
Imbalance	☐	☐
Memory loss	☐	☐
Arm/Leg weakness	☐	☐
Psychiatric:		
Anxiety	☐	☐
Depressed mood	☐	☐
Suicidal thoughts	☐	☐
Hallucinations	☐	☐

Any other concern not listed above: _____

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I hereby certify that the above information is true and correct to the best of my knowledge.

Patient/Representative Name (Print): _____

Signature: _____ Date: ___/___/___

FOR OFFICE USE ONLY:
Document reviewed by: _____ Date: ___/___/___

Entered into chart_____(Initials**)**