GRANGER MEDICAL CLINIC

Pinky Kotwal, MD
11724 S. State St., Draper, UT 84020
office 801.576.2065

New Patient Registration Form

Patient Name: _____ Date: _____

DOB: _____ Acct. #: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling/staying asleep OR sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite OR overeating				
6. Feeling bad about yourself or that you're a failure, or have let yourself or family down				
7. Trouble concentrating on things such as reading the newspaper or watching TV				
8. Moving or speaking so slowly that other people have noticed OR restlessness/fidgeting, can't sit still				
9. Thoughts that you would be better off dead or thoughts of hurting yourself				
SCORE:				

What brings you to the clinic: _____

_____

Occupation: _____

Medical Problems and Year Diagnosed:

_____ _____

_____ _____

_____ _____

_____ _____

Surgeries:

_____ _____

_____ _____

Hospital Admission(s):

_____ _____

_____ _____

Serious Illness: _____

Medications (include name and dosage):

_____ _____

_____ _____

_____ _____

_____ _____

Please list all medical conditions/diseases that run in your family:

Mother: _____ Living / Deceased Age: _____

Father: _____ Living / Deceased Age: _____

Brother: _____ Living / Deceased Age: _____

Sister: _____ Living / Deceased Age: _____

Others: _____ Living / Deceased Age: _____

Do you smoke tobacco? YES / NO If yes, how much? _____

Do you drink alcohol excessively? YES / NO If yes, how much? _____

Do you drink Coffee? YES / NO If yes, how much? _____

Are your immunizations current? YES / NO

Immunizations	Year Received
Tetanus	_____
Pertussis	_____
Gardasil (HPV)	_____
Shingles	_____
Other	_____

Test	Year Received
Colonoscopy	_____
Mammogram	_____
Pap Smear	_____
PSA	_____
Hepatitis C	_____

Implants? YES / NO If yes, when? _____

Please circle any symptoms you are having now or have recently had:

NEUROLOGIC	HEENT	RESPIRATORY	CARDIAC
Headaches	Hearing loss	Cough	Chest Pain
Confusion	Ear pain	Shortness of breath	Hypertension
Numbness	Vision changes	Pain when breathing	Leg/Ankle swelling
Dizziness	Sore throat	Sputum	Rheumatic fever
Head injury	Sinus trouble	Coughing blood	Heart murmurs
Paralysis	Hay fever	Pneumonia	Heart trouble
Dizzy spells		LAST X-RAY: _____	
Fainting			
Double vision			
Convulsions			
Weakness			
Decreased vision			

GASTROENTEROLOGY	CONSTITUTIONAL	MUSCULOSKELETAL	URINARY
Abdominal pain	Fevers/Chills	Joint pain	Pain when urinating
Nausea or vomiting	Night sweats	Joint swelling	Urinating at night
Constipation/Diarrhea	Rash	Muscle pain	Blood in urine
Blood in stool	Fatigue	Weakness	Dribbling
Heartburn		Popping	Kidney infection
Appetite			Trouble with stream
Weight Loss/Gain			
Trouble swallowing			
Yellow jaundice			
Black/Tarry stool			

FEMALE ONLY

Circle any symptoms you are having now or have recently had:

Abnormal bleeding	Pain	Irregular periods
Hot flashes	Menstrual pain	Heavy menses

Number of Children: _____ Abnormal Deliveries: _____

Abortions: _____

Last Period: _____ Menopause? YES / NO If yes, when? _____