Return this form at least 5 days prior to your appointment.
If this form is not returned your appointment may be cancelled.
You may fax this form back to 317-872-1186.

PATIENT INFORMATION SHEET
ARREGUI, DAVIS, SINGH & MATHAVAN MDs, INC

Appt Date _____ Arregui ☐ Davis ☐ Singh ☐ Mathavan ☐

DEMOGRAPHICS

Last Name _____ First Name _____ MI _____ Gender Female
SSN _____ Date of Birth _____ Marital Status _____
Street _____ City/State/Zip _____
Home Phone _____ Work Phone _____ Employer _____
Cell# _____ Email: _____

INSURANCE

Primary	Secondary	Other
Carrier _____	Carrier _____	Carrier _____
ID# _____	ID# _____	ID# _____
Group # _____	Group # _____	Group # _____

EMERGENCY CONTACT

#1 Last Name _____ First Name _____ Relationship _____
Home Phone _____ Work Phone _____ Cell/Pager# _____
#2 Last Name _____ First Name _____ Relationship _____
Home Phone _____ Work Phone _____ Cell/Pager# _____

PHYSICIANS

REFERRING	FAMILY	CARDIOLOGIST
Last Name _____	Last Name _____	Last Name _____
First Name _____	First Name _____	First Name _____
Office Phone# _____	Office Phone# _____	Office Phone# _____

OTHER	OTHER	OTHER
Last Name _____	Last Name _____	Last Name _____
First Name _____	First Name _____	First Name _____
Office Phone# _____	Office Phone# _____	Office Phone# _____

PREVIOUS SURGERIES & PROCEDURES

TYPE OF SURGERY/YEAR OF SURGERY	TYPE OF SURGERY/YEAR OF SURGERY
1 _____	5 _____
2 _____	6 _____
3 _____	7 _____
4 _____	8 _____
4 _____	8 _____

Tobacco Use (Circle all that apply)

Do You Smoke or Chew Tobacco: Y ☐ or N ☐ When did you quit smoking: _____

If yes or if you quit, how many pks per day: _____ _____

How many years did you or have you smoked: _____

ALCOHOL USE (CHECK WHICH APPLIES)

Daily ☐ Occ. ☐ Heavy ☐ Socially ☐ Never ☐

PAST MEDICAL HISTORY

CHECK ANY OF THE FOLLOWING CONDITIONS THAT APPLY & DESCRIBE THE CONDITION

Heart Disease _____

Pacemaker or Defibrillator Make/Model#/Serial# _____

Lung Problems or Asthma _____

High Blood Pressure _____

Diabetes _____

Colon or Bowel _____

Cancer _____

Stroke or Mini Stroke _____

Bleeding Tendencies _____

Blood Clots or Cellulitis _____

Others (please list) _____

PRESCRIPTION MEDICATIONS

Medication	Dose/Frequency	Medication	Dose/Frequency
1		7	
2		8	
3		9	
4		10	
5		11	
6		12	

NON-PRESCRIPTION MEDICATIONS

OVER-THE-COUNTER (INCLUDING ASPIRIN)	HERBAL PREPARATIONS & DIETARY SUPPLEMENTS
1	1
2	2
3	3
4	4
5	5
6	6

ARE YOU ALLERGIC TO ANY MEDICATIONS, FOODS OR PRODUCTS? WHAT TYPE OF REACTION?

1	3
2	4

FAMILY MEDICAL HISTORY (Do any family members, alive or deceased, have medical problems?)

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

REVIEW OF SYSTEMS

(Circle any of the following you currently experience)

General
Weight loss
Weight gain
Fever
Fatigue

Eyes
Pain
Discharge
Light sensitivity
Blurred vision

ENT
Sore throat
Hoarseness
Ear ringing
Nose bleeds

Respiratory
Wheezing
Cough
Shortness of breath
Chest congestion

Cardiovascular
Chest Pain
Fainting
Swelling of feet
Palpitations
Swelling of hands

Genitourinary
Painful urination
Hesitancy
Urgency
Blood in urine
Flank pain

Neurological
Headache
Confusion
Numbness
Slurred speech
Dizziness/Vertigo
Extremity Weakness
Extremity Paralysis

Musculoskeletal
Joint swelling
Joint pain
Back pain
Muscle cramps
Muscle weakness

Skin
Rash
Itching
Sores
Abscess
Discharge

Endocrine
Excessive sweating
Excessive thirst
Heat intolerance
Excessive urination
Excessive hunger

Hematologic/Lymph
Lymph node swelling
Easy bruising
Bleeding
Skin discoloration

Allergic/Immunologic
Seasonal allergies
hives
persistent infections

Psychologic
Anxiety
Depression
Severe stress
Panic Attacks

Gastrointestinal
Abdomen pain
Unusual belching
Nausea
Vomiting
Diarrhea
Constipation
Blood in stool
Dark, tarry stool
Bloating
Change in bowel habits
Indigestion
Excessive gas
Difficult ty Swallowing
Yellow skin color

History of the following:
MRSA
VRE

HEIGHT _____ **WEIGHT** _____