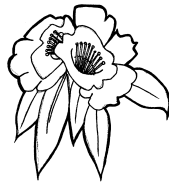


Pratistha Strong, D.O.  
**Kathmandu Clinic**  
10807 Big Bend Blvd., Ste 1  
Kirkwood, MO 63122



Cell: 918-814-3996  
Fax: 432-614-2599  
pratistha.strong@gmail.com  
www.doctorpstrong.com

Name: \_\_\_\_\_ Date: \_\_\_\_\_

May Dr. Strong leave medical information on your answering machine/voicemail? **YES NO**

May Dr. Strong send medical information to your email? **YES NO**

May Dr. Strong send non-medical information (newsletters) to your email ? **YES NO**

May Dr. Strong text messages medical information to your phone? **YES NO**

**Patient Profile**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone# (H): \_\_\_\_\_ (W): \_\_\_\_\_ Other: \_\_\_\_\_

Email: \_\_\_\_\_

Spouse/Significant Other: \_\_\_\_\_

Children's names and ages: \_\_\_\_\_

Patient Employer: \_\_\_\_\_ Address: \_\_\_\_\_

**Responsible Party (complete if different than patient)**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone# (H): \_\_\_\_\_ (W): \_\_\_\_\_ Other: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

**Emergency Contact**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Preferred Pharmacy** Name/Address: \_\_\_\_\_

Office: \_\_\_\_\_ Fax: \_\_\_\_\_

Please list names: include physical therapy, psychology, acupuncture, massage, diet, chiropractor:

**Your Health Care Provider:** \_\_\_\_\_

Address: \_\_\_\_\_

Office: \_\_\_\_\_ Fax: \_\_\_\_\_

**Your Health Care Provider:** \_\_\_\_\_

Address: \_\_\_\_\_

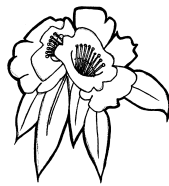
Office: \_\_\_\_\_ Fax: \_\_\_\_\_

**Your Health Care Provider(s):** \_\_\_\_\_

Address: \_\_\_\_\_

Office: \_\_\_\_\_ Fax: \_\_\_\_\_

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Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Health Information**

**Current Medications** (Include all prescriptions and over the counter drugs, supplements, herbals)

**NO CURRENT MEDICATIONS**

Medication Name	Dosage Amount (Ex. 15 mg, 2 puffs, 5 meq)	Take (Ex. 1 tablet, 2 tablets 1 to 2 tablets)	Frequency (Ex. Once a day, Twice a day, as needed)	Reason for Medication (Ex. High blood pressure, diabetes, high cholesterol)

**Medication Allergies:** (List Reactions or write unknown):

**NO KNOWN DRUG ALLERGIES**

\_\_\_\_\_

\_\_\_\_\_

**Past (or Current) Medical History** (circle all that apply):

- |                    |                      |                     |                       |                    |
|--------------------|----------------------|---------------------|-----------------------|--------------------|
| Acne               | Depression           | Headaches           | Impotence             | Rosacea            |
| Anxiety            | Diabetes             | Heart Attack        | Infertility           | Seasonal Allergies |
| Asthma             | Eczema               | Heart Disease       | Migraines             | Seizures           |
| Bleeding Disorders | Emphysema            | Heart Murmur        | Mitral Valve Prolapse | Sleep Disorder     |
| Cancer _____       | Erectile Dysfunction | Hemorrhoids         | Nerve Damage          | Stomach            |
| Cirrhosis          | Fibromyalgia         | Hepatitis           | Psoriasis             | Stroke             |
| Concussion         | Gallstones           | High Blood Pressure | Prostate              | Thyroid Disease    |
| COPD               | Glaucoma / Cataracts | HIV / AIDS          | Rheumatic Fever       | Tuberculosis       |
|                    |                      |                     |                       | Ulcers             |
|                    |                      |                     |                       | Venereal Diseases  |

Other: \_\_\_\_\_

Psychiatric History:

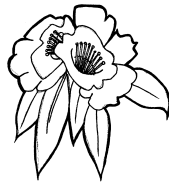
Have you ever been treated for emotional problems? Yes or No  
 Have you ever considered attempted suicide? Yes or No



**Men's History:**

Diagnosed with prostate cancer? (date of diagnosis): \_\_\_\_\_  
 Urinary issues?(increased frequency/not emptying/night time): \_\_\_\_\_  
 \_\_\_\_\_  
 PSA level / date: \_\_\_\_\_  
 Erectile dysfunction? \_\_\_\_\_

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Name: \_\_\_\_\_ Date: \_\_\_\_\_

STD checked /date? \_\_\_\_\_

**GYN History:**

First day of LMP \_\_\_\_\_ Age at first menstrual period \_\_\_\_\_

# of days between periods: \_\_\_\_\_ Length of periods: \_\_\_\_\_

Age at menopause: \_\_\_\_\_

Method of birth control: Condoms Oral Contraceptive IUD Shot None Other: \_\_\_\_\_

Date of last PAP: \_\_\_\_\_ Results: Normal or Abnormal

History of abnormal PAP? Yes or No Treatment (if any): \_\_\_\_\_

Do you do self-breast exams? Yes or No Have you ever found a lump? Yes or No

Sexual dysfunction? \_\_\_\_\_

**OB History:** Total # of pregnancies: \_\_\_\_\_ Total # full term deliveries: \_\_\_\_\_

Total # of preterm deliveries: \_\_\_\_\_ Total # of miscarriage(s): \_\_\_\_\_

Total # of abortions: \_\_\_\_\_ Total # of ectopic pregnancies: \_\_\_\_\_

Total # of multiple birth(s): \_\_\_\_\_

**Surgeries:** (include all dates): \_\_\_\_\_

Have you been **hospitalized** for anything besides surgery? \_\_\_\_\_

**Accidents/Traumas:** (include all dates): \_\_\_\_\_

**Family History:** Please list if your **mom, dad, brothers, sisters, children**, have had any of the following? If any of these individuals have passed away, please write age at death and reason.

# of Siblings: Brothers \_\_\_\_\_ Healthy Sisters \_\_\_\_\_ Healthy

# of Children: Sons \_\_\_\_\_ Healthy Daughters \_\_\_\_\_ Healthy

Mother: Healthy / Passed away / Asthma / Cancer (which type: \_\_\_\_\_) / Diabetes / Depression or suicide / Heart problems / High blood pressure / High cholesterol / Thyroid problems/ Stroke / Other:

Father: Healthy / Passed away / Asthma / Cancer (which type: \_\_\_\_\_) / Diabetes / Depression or suicide / Heart problems / High blood pressure / High cholesterol / Thyroid problems/ Stroke / Other:

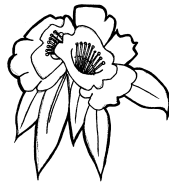
Brothers 1: Healthy / Passed away / Asthma / Cancer (which type: \_\_\_\_\_) / Diabetes / Depression or suicide / Heart problems / High blood pressure / High cholesterol / Thyroid problems/ Stroke / Other:

Brothers 2: Healthy / Passed away / Asthma / Cancer (which type: \_\_\_\_\_) / Diabetes / Depression or suicide / Heart problems / High blood pressure / High cholesterol / Thyroid problems/ Stroke / Other:

Sisters 1: Healthy / Passed away / Asthma / Cancer (which type: \_\_\_\_\_) / Diabetes / Depression or suicide / Heart problems / High blood pressure / High cholesterol / Thyroid problems/ Stroke / Other:

Sisters 2: Healthy / Passed away / Asthma / Cancer (which type: \_\_\_\_\_) / Diabetes / Depression or suicide / Heart problems / High blood pressure / High cholesterol / Thyroid problems/ Stroke / Other:

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Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Social History:**

What level of education did you finish? \_\_\_\_\_

Any barriers to learning?

Language  Culture  Hearing  Vision  Permanent Cognitive Impairment  None

Do you use tobacco? Yes or No What type? \_\_\_\_\_ Amount? \_\_\_\_\_

How many years of tobacco use? \_\_\_\_\_ Quit date: \_\_\_\_\_

Do you drink alcohol? Yes or No Quit date: \_\_\_\_\_

If yes, how often did you have 5 or more drinks (as a man) or 4 or more drinks (as a woman) on one occasion in the past year?  1 or more  Daily  Weekly  Monthly  Never

Do you use cannabis? Yes or No What form? \_\_\_\_\_ Freq: \_\_\_\_\_ Brand: \_\_\_\_\_

How long have you been using cannabis: \_\_\_\_\_

Do you use CBD? Yes or No What form? \_\_\_\_\_ Freq: \_\_\_\_\_ Brand: \_\_\_\_\_

Do you use illicit drugs? Yes or No What type? \_\_\_\_\_ Quit date: \_\_\_\_\_

Caffeine intake:  Coffee  Soda  Tea  Energy Drink  None How often? \_\_\_\_\_

Exercise regularly? Yes or No How many times per week? \_\_\_\_\_ Type: \_\_\_\_\_

Do you always wear a seatbelt in the car? \_\_\_\_\_

Do you have firearms in your home? \_\_\_\_\_ locked/unloaded? \_\_\_\_\_

Do you have problems with sleep? Please elaborate if you wish.

Do you have problems with stress? Please elaborate if you wish.

Special diets? \_\_\_\_\_ Reason? \_\_\_\_\_

What is your typical diet consist of in a 24 hour period? (Breakfast, lunch, dinner. Oils you cook with; fast food frequency; frequency of home cooked meals; water intake)

Breakfast:

Snacks:

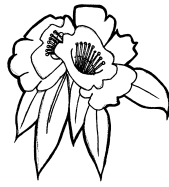
Lunch:

Water:

Dinner:

Are you in pain? Please elaborate if you wish.

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Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Sexual History:** (Leave any questions blank if you are uncomfortable answering them. Feel free to discuss any concerns with Dr. Strong.)

Do you identify as a: Male Female Transgender Other

Have you ever had sexual intercourse? Yes or No If yes, the following will apply:

Are you currently sexually active? Yes or No

Have your sexual partners been: Men or Women or Both

What was your age at first intercourse? \_\_\_\_\_

Total number of sexual partners/encounters: \_\_\_\_\_ Number of sexual partners/encounters in the last 12 months: \_\_\_\_\_

Have you had intercourse without contraception since your last menstrual period? Yes or No

Have you had intercourse without a condom since your last STD testing? Yes or No

Does your partner have any symptoms of infection? Yes or No

Have you experienced any unwanted sexual encounters? Yes or No

**Health Maintenance:**

Eye exam: When was your last exam? \_\_\_\_\_

Dental exam: When was your last exam? \_\_\_\_\_

Hearing exam: When was your last exam? \_\_\_\_\_

Immunizations up to date? Yes or No Reason if No: \_\_\_\_\_

Flu Vaccination (ALL AGES): When was your last flu shot? \_\_\_\_\_

Tetanus within 10 years? Yes or No

Hepatitis B series? (childhood vacc. 1994) Yes or No

Gardasil (HPV)? Yes or No

Pneumonia Vaccine (65 YEARS AND OLDER)

Have you had a pneumonia vaccine? YES or NO

If yes, where/when was your last Pneumonia vaccination? \_\_\_\_\_

Colonoscopy (IF YOU ARE BETWEEN THE AGES 50 - 75 YEARS OLD)

Have you ever had a colonoscopy? YES or NO

If yes, when/where/results? \_\_\_\_\_

If no, would you be interested in having one? YES NO

Mammogram (IF YOU ARE A WOMAN BETWEEN 50 - 75 YEARS OLD)

When/where was your last mammogram? \_\_\_\_\_

Results of last mammogram? \_\_\_\_\_

Bone Density Scan or DEXA (IF YOU HAVE HAD ONE IN THE LAST 2 YEARS)

Have you ever had a DEXA? YES or NO

If yes, When/Where was your last DEXA? \_\_\_\_\_

What are your health goals?

What is your life purpose?

Anything else you wish to share?