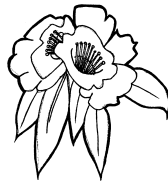
Pratistha Strong, D.O.
Kathmandu Clinic
10807 Big Bend Blvd., Ste 1
Kirkwood, MO 63122



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 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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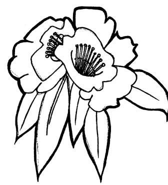

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Name:____ Date:__________________

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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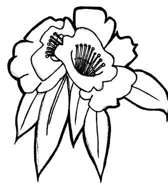

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Name:____ Date:____________

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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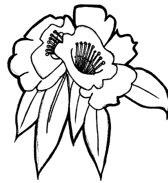

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Name:____ Date:________________

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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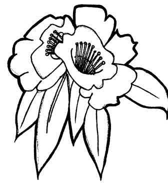

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Sexual History: (Leave any questions blank if you are uncomfortable answering them. Feel free to discuss any concerns with Dr. Strong.)
Do you identify as a: Male Felmale Transgender Other

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?