MAB
MEDICAL ASSOCIATES OF BREVARD
A Multi-Specialty Group Practice

Mudanai Sabapathy, M.D.
Internal Medicine
Geriatric Medicine
3044 W. New Haven Ave
W. Melbourne, FL 32904
Phone (321) 473-8613
Fax (321) 914-0229

PATIENT QUESTIONNAIRE

Last Name: ________________________ First Name: ________________ Date of Birth:________

Male ☐ Female ☐ Occupation ______________________________________

Marital Status: ☐Single ☐Partnered ☐Married ☐Separated ☐Divorced ☐Widowed

Previous doctor: __________________________ Date of last physical examination: ______________

PERSONAL HEALTH HISTORY

Immunizations and Dates

Tetanus ☐ Date: __________ Pneumonia ☐ Date: __________ Hepatitis ☐ Date: __________

Influenza ☐ Date: __________ COVID-19 ☐ Date: __________ Shingles ☐ Date: __________

MEDICAL HISTORY

☐Alcohol/Drug Problem
☐Anemia
☐Anxiety
☐Arthritis
☐Asthma
☐Atrial fibrillation
☐Dementia
☐Diabetes
☐Cancer
☐Peripheral artery disease
☐Emphysema/COPD
☐Heart Attack
☐Coronary artery disease
☐Heart failure / CHF
☐High Blood Pressure
☐High Cholesterol
☐Hypothyroidism (low)
☐Hyperthyroidism (high)
☐Kidney disease
☐Liver Disease
☐Osteoporosis
☐Prostate problem
☐Depression
☐Psychiatric problem
☐Seizure Disorder
☐Stroke / CVA / TIA
☐Stomach ulcers
☐STDs/sexual infection
☐Positive TB test
☐Blood Clots
☐Acid reflux
☐Neuropathy
☐Sleep apnea
☐Heart murmur
☐Migraines
☐Hepatitis
☐Diverticulosis
☐Colon Polyps
☐Abnormal PAP test
☐Other: ____

SURGERIES

☐Appendectomy
☐Hysterectomy
☐Tubal ligation
☐Tonsillectomy
☐Prostate surgery
☐Cataract surgery
☐C-section
☐Gallbladder
☐Breast surgery
☐Cardiac Bypass
☐Vasectomy
☐Hernia repair
☐Heart stent / Angioplasty
☐Other Surgeries/Hospitalizations: ______________________________________

SCREENING TESTS

Colonoscopy ☐ Date: ________ Mammogram ☐ Date: ________ PAP smear ☐ Date: __________

Prostate test/PSA ☐ Date: ______ Bone density test/DEXA ☐ Date: ______ Eye exam ☐ Date: ______

over

MEDICATIONS: List prescribed and over-the-counter medications

DRUG NAME:	DOSE & DIRECTIONS:	REASON:	PHARMACY:

ALLERGIES / REACTIONS TO MEDICATIONS

DRUG NAME:	REACTION / COMMENTS:

LIST ANY FOOD OR ENVIRONMENTAL ALLERGIES AND REACTIONS

____

____

SOCIAL HISTORY

Do you smoke currently? ______________________
How many packs per day? ______________________
For how many years? __________________________

Did you smoke previously? _____________________
If yes, how many packs per day? ________________
For how many years? __________________________
When did you quit? ____________________________

How many alcoholic drinks do you ingest per week on average? ____________________________________

Do you currently use any illicit / illegal drugs? _______

FAMILY HISTORY

Do you have any grandparents, parents, siblings, or children with any of these problems?

	Grandparent	Father	Mother	Siblings	Children
Diabetes					
Heart Disease					
Cancer					
High Blood pressure					
Stroke					