Kavita Shah Patel, MD

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Mobile Number: _____ Email: _____

Who Referred You:_____ Gender: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relation: _____

Mobile Number:_____

Address: _____

PHARMACY INFORMATION

Pharmacy Name:_____

Phone:_____

Address: _____

Allergies to Medications: _____

Last Covid vaccination or booster date: _____

ACKNOWLEDGEMENTS AND ADDITIONAL QUESTIONS

_____ (INITIALS) I understand Dr. Kavita Shah Patel may order routine labs (including screening for sexually transmitted disease), studies, or treatment, which may be sent to labs, companies, or pharmacies in which Dr. Kavita Shah Patel is financially invested. I am under no obligation to use these facilities.

_____ (INITIALS) I understand that a $20 service fee will be added to my current billing statement for any office visit missed without a prior 24 hour notification.

_____ (INITIALS) I understand that I am personally responsible for all charges incurred by me for professional services provided by this office. A separate bill for laboratory or radiology services may be received for which I am responsible. The billing department is available to answer any questions.

_____ (INITIALS) Dr. Shah Patel's office may phone, email or text you to confirm appointments.

_____ (INITIALS) Dr. Shah Patel's office may leave a message on your voicemail at home or on your cell.

Please list the names of people we may discuss your medical condition with:

_____

Patient Signature:_____ **Date:**_____

KAVITA SHAH PATEL, MD

KSP

INTERNAL MEDICINE

Kavita Shah Patel, MD

MEDICAL SCREENING HISTORY

Colonoscopy	**Year:** _____	**Physician:** _____
Mammogram	**Year:** _____	**Location:** _____
Pap Smear	**Year:** _____	**Physician:** _____
Prostate Exam	**Year:** _____	**Physician:** _____
Bone density	**Year:** _____	**Location:** _____
Echocardiogram	**Year:** _____	**Physician:** _____
Arterial Brachial Index	**Year:** _____	**Physician:** _____
Carotid Dopplers	**Year** _____	**Physician:** _____
Stress test or cardiac cath	**Year:** _____	**Physician:** _____
CT Chest (for smokers)	**Year:** _____	**Location:** _____
Abdominal Ultrasound (for smokers)	**Year:** _____	**Location:** _____
Dental examination	**Year:** _____	**Dentist:** _____

MEDICATION LIST

	Name of Medication	Dose	How Often
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

KAVITA SHAH PATEL, MD
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INTERNAL MEDICINE

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PATIENT HEALTH QUESTIONNAIRE

Over the last two weeks, how often have you been bothered by any of the following problems?

	Not At All (0)	Several Days (1)	More Than ½ the Time (2)	Nearly Every Day (3)
Little interest or pleasure in doing things				
Feeling down, depressed, hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself, or that you are a failure, or that you have let someone down				
Trouble concentrating on things such as reading or watching television				
Moving or speaking so slowly that other people could have noticed. or the opposite, being so fidgety or restless that you move around a lot more than usual.				
Thoughts that you would be better off dead, or hurting yourself				
Subtotals				

TOTAL	

If you checked off any problems, how difficult have these problems made it for you to work, take care of things at home, or get along with other people?

_____ Not difficult at all
_____ Somewhat difficult
_____ Very difficult
_____ Extremely difficult

SLEEP APNEA BERLIN QUESTIONNAIRE

Category 1

1. Do you snore?

□ a. Yes

□ b. No

□ c. Don't know

IF 'YES':

2. You snoring is:

□ a. Slightly louder than breathing

□ b. As loud as talking

□ c. Louder than talking

3. How often do you snore?

□ a. Almost every day

□ b. 3-4 times per week

□ c. 1-2 times per week

□ d. 1-2 times per month

□ e. Rarely or never

4. Has your snoring ever bothered other people?

□ a. Yes

□ b. No

□ c. Don't know

5. Has anyone noticed that you stop breathing during your sleep?

□ a. Almost every day

□ b. 3-4 times per week

□ c. 1-2 times per week

□ d. 1-2 times per month

□ e. Rarely or never

Category 2

6. How often do you feel tired or fatigued after your sleep?

□ a. Almost every day

□ b. 3-4 times per week

□ c. 1-2 times per week

□ d. 1-2 times per month

□ e. Rarely or never

7. During your waking time, do you feel tired, fatigued or not up to par?

□ a. Almost every day

□ b. 3-4 times per week

□ c. 1-2 times per week

□ d. 1-2 times per month

□ e. Rarely or never

8. Have you ever nodded off or fallen asleep while driving?
□ a. Yes

□ b. No

IF 'YES':

9. How often does this occur?

□ a. Almost every day

□ b. 3-4 times per week

□ c. 1-2 times per week

□ d. 1-2 times per month □ e. Rarely or never

Category 3
10. Do you have high blood pressure?

□ Yes

□ No

□ Don't know

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ALLERGY QUESTIONNAIRE

Please check YES or NO:

Smoker	☐ YES	☐ NO
Nasal trouble	☐ YES	☐ NO
Sinus trouble	☐ YES	☐ NO
Hay fever	☐ YES	☐ NO
Shortness of breath	☐ YES	☐ NO
Chronic cough	☐ YES	☐ NO
Latex reaction	☐ YES	☐ NO
Asthma	☐ YES	☐ NO
Hives	☐ YES	☐ NO
Eczema	☐ YES	☐ NO
Bee sting reaction	☐ YES	☐ NO
Medication reaction	☐ YES	☐ NO
Plugged nose	☐ YES	☐ NO
Mouth breathing	☐ YES	☐ NO
Runny nose	☐ YES	☐ NO
Post nasal drainage	☐ YES	☐ NO
Sneezing	☐ YES	☐ NO
Nasal itching	☐ YES	☐ NO
Itchy eyes	☐ YES	☐ NO
Red eyes	☐ YES	☐ NO
Watery eyes	☐ YES	☐ NO
Swollen eyes	☐ YES	☐ NO
Sinus pressure / headaches	☐ YES	☐ NO
Ear plugging	☐ YES	☐ NO
Wheezing	☐ YES	☐ NO
Itchy skin	☐ YES	☐ NO

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GENERAL HEALTH QUESTIONNAIRE

Check YES if you are over 45 and have NOT had a stress test

☐ YES ☐ NO

Do you have a family history of heart disease or stroke?

☐ YES ☐ NO

Do you experience shortness of breath at rest or during exertion?

☐ YES ☐ NO

Do you experience chest pain, tightness, pressure, or discomfort?

☐ YES ☐ NO

Have you ever been told you had diabetes or a problem with high blood sugar?

☐ YES ☐ NO

Do you have high blood pressure?

☐ YES ☐ NO

Do you currently smoke or have a history of smoking?

☐ YES ☐ NO

Do you have asthma, exercise induced asthma, COPD, emphysema, a persistent cough or chronic bronchitis?

☐ YES ☐ NO

Have you been diagnosed with sleep apnea?

☐ YES ☐ NO

Have you had any episodes of dizziness or fainting?

☐ YES ☐ NO

Have you ever had an abnormal EKG?

☐ YES ☐ NO

Do you have any Metabolic or Thyroid disorders?

☐ YES ☐ NO

Do you ever have numbness, tingling, pain, or swelling in your arms or legs?

☐ YES ☐ NO

Kavita Shah Patel, MD

HIPAA COMPLIANCE PATIENT CONSENT FORM

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

We may use or share your medical information without your permission for the following:

- So you can get medical care. For example, we may share your medical information with your doctors or pharmacies so that they can provide you with appropriate medical care.
- So we can perform our duties. For example: to assess quality of care; to manage your care; or for audits.
- To inform you about other health services.
- To comply with the law.
- For other reasons:
  - To comply with with legal proceedings, such as a court or administrative order or subpoena;
  - To enforce other laws or protect one's health and safety;
  - So a family member, friend, or other person can help you to get or pay for your health care;
  - So a personal representative you appoint or a court appoints for you can help you get health benefits
  - To support research as long as the information will be protected by the researchers;
  - So a coroner or medical examiner can identify a deceased person or cause of death or so a funeral director can arrange burial;
  - To appoint an organ procurement organization in limited circumstances;
  - To protect you against a serious threat to your health or safety or the health or safety of others;
  - To support a government agency overseeing health care programs;
  - For lawful national security purposes;
  - For public health purposes and for military purposes, if you are a member of the armed forces.

We will not share your medical information for any other reason unless you give us written permission. You may withdraw your permission in writing at any time. Your permission for us to use or have your information will end when we get your written notice withdrawing our permission.

Your rights. You may ask us in writing to do any of the following. We will decide if it can be done based on the Privacy Protection Standards outlined in HIPAA.

- You may ask us not to sue or share your medical information.
- You may ask us to contact you about your medical information privately in a different way or at a different place than we are currently doing.
- You may ask to see or obtain copies of your medical information. You may be charged a fee for copies.
- You may ask us to correct your medical information.
- You may ask for a list of ways we shared your medical information for up to six years.

Complaints. If you believe we have not protected your right to privacy you have the right to complain to us or the Secretary of the U.S. Department of Health and Human Services.

We reserve the right to change our privacy practices. If you have any questions, contact us at 832-255-6631.

I understand and accept the terms of these practices.

Patient Signature:_____ **Date:**_____

KAVITA SHAH PATEL, MD

KSP

INTERNAL MEDICINE

Dr. Kavita Shah Patel, MD

Medical Center Location
7015 Almeda Road
Houston, TX 77450
Ph: 832-255-6631
Fax: 832-255-6620

West Houston/Katy Location
19255 Park Row Drive, Ste 205
Houston, Texas 77084
Ph: 832-255-6631
Fax: 832-255-6620

REQUEST FOR MEDICAL RECORDS RELEASE

The following individual has asked us to request that his or her medical records be released and forwarded to our office.

Patient Name: _____ **Date of Birth: _____**

In order for us to fully evaluate the patient's health and make informed decisions, the patient has approved our request for copies of all relevant medical records in your file. Please include office notes, laboratory and imaging results.

Thank you for expediting this request. Please mail or fax these records to our office.

I hereby authorize the release of all necessary medical records to Dr. Kavita Shah Patel, MD. I wish for them to be forwarded as soon as possible.

Patient Signature:_____ **Date:_____**