SAI Medical Care
800 Bonaventure Way Unit 128
Sugar Land, Texas 77479
Phone: 832-532-0370
Fax: 832-440-1343

Suman Ravuri MD PA

Existing Patient Intake Form

Please fill in all information as accurately as possible

Patient Information

Patient Name:_____ Date of Birth: ____/_____/____ Sex: M / F / Other:_____

If any information below has changed since your last visit, please fill out as accordingly, if not check here ☐

(Circle One) Married/Single/Divorced/Widow
Address: _____
(Street) (City/State/Zip)
Home Phone: (____) _____-_____ E-Mail Address: _____
Cell Phone: (____) _____-_____
Who to call for an emergency:
Name: _____ Address: _____
Cell Phone: (____) _____-_____ Relationship: _____

Insurance Information

If any information below has changed since your last visit, please fill out as accordingly, if not check ☐

Primary Insurance
Plan Name: _____ I.D. Number:_____
Group Name: _____ Policy Holder Name: _____
Policy Holder's Date of Birth: _____ Effective Date: _____
Policy Holder's Social Security Number: ____- ____-____
Patent Relationship to Policy Holder:_____
Secondary Insurance (*If applicable*)
Plan Name: _____ I.D. Number:_____
Group Name: _____ Policy Holder Name: _____
Policy Holder's Date of Birth: _____ Effective Date: _____
Policy Holder's Social Security Number: ____- ____-____
Patent Relationship to Policy Holder:_____

Additional Information

Have you been fully vaccinated for COVID-19? ___ One dose ___ Both dose ___ Booster Vaccine ___ None

Have you received your flu vaccine for 2021? ____ Yes ____ No ____ Would like one today? Yes or No *(please circle)*

If you fall under the criteria of hypertension and hyperlipidemia, would you like to hear more information about obtaining a free blood pressure monitor device? YES ☐ NO ☐

Preferred Pharmacy (*If any changes)*
Pharmacy Name:_____ Pharmacy Address: _____

Family or Other Physician Involved in your care: ***(If any changes or additional care)***
Physician's Name: _____ Specialty: _____
Physician's Address: _____ Physician's Number: _____
(Please use space below to list other physician's involved in your care if applicable)

Patient Initial: _____

Back copy as well

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Medical Intake Information

If any information below has changed since your last visit, please fill out as accordingly, if not check ☐

Allergies

☐ No known Allergies
☐ No known drug Allergies

If any allergies please list below:
_____
_____

Smoking Status

☐ Never smoker
☐ Former smoker
☐ Current every day smoker
☐ Current some day smoker

If current or former smoker how many packs and how long?
_____

Alcohol Status

☐ Do not drink
☐ Drink daily
☐ Frequently drink
☐ Hx of Alcoholism
☐ Occasional drink

Medical History

☐ Hypertension
☐ Heart Attack
☐ Hypothyroidism
☐ Asthma
☐ Pneumonia
☐ Ulcer or GI disorder
☐ Diabetes Type 1 or 2
☐ Arthritis
☐ Sexual/menstrual dysfunction
☐ Osteoporosis
☐ Stroke
☐ Depression
☐ Heart Disease
☐ Other_____

Current Medications

☐ No known medications
☐ I take the following prescription below (*Please include dose and how often)*
_____
_____
_____
_____
_____

Hospitalization or Surgery

☐ No hospitalizations
☐ No Surgery

If any Hospitalizations or Surgeries please list below in detail and with a date:
_____
_____
_____
_____

Family History

Mother's Parents	Father's Parents	Mother	Father	
☐ -	☐ -	☐ -	☐ -	Alive
☐ -	☐ -	☐ -	☐ -	Deceased
☐ -	☐ -	☐ -	☐ -	No Health Concern
☐ -	☐ -	☐ -	☐ -	Heart Disease
☐ -	☐ -	☐ -	☐ -	Heart Attack
☐ -	☐ -	☐ -	☐ -	Stroke
☐ -	☐ -	☐ -	☐ -	High Cholesterol
☐ -	☐ -	☐ -	☐ -	Cancer
☐ -	☐ -	☐ -	☐ -	Diabetes Type 1 or 2
☐ -	☐ -	☐ -	☐ -	Kidney Disease
☐ -	☐ -	☐ -	☐ -	Osteoporosis
☐ -	☐ -	☐ -	☐ -	Thyroid Disease
☐ -	☐ -	☐ -	☐ -	Bleeding Disorder
☐ -	☐ -	☐ -	☐ -	Epilepsy/Convulsion
☐ -	☐ -	☐ -	☐ -	Asthma
☐ -	☐ -	☐ -	☐ -	Multiple Sclerosis
☐ -	☐ -	☐ -	☐ -	Alzheimer's

Patient Signature: _____