Dallas Medical
Doctors of Internal Medicine

Vijaya Mummadi, M.D.

8210 Walnut Hill Ln., Ste 306, Dallas, TX 75231, Phone 214-306-4030, Fax: 214-242-6758

NEW PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Name: _____ **DOB:** _____

Medical History

ALL medications and supplements taken regularly: [ ] Separate list attached

Drug Name	Dose	# Times / day	Drug Name	Dose	# Times / day

Allergies to medications: [ ] No known drug allergies [ ] Separate list attached

Drug	Reaction	Drug	Reaction

Previous surgeries: [ ] Separate list attached

Date	Type of surgery	Date	Type of surgery

Previous hospitalizations *not including* surgeries [ ] Separate list attached

Date	Reason	Date	Reason

All medical problems not listed above: [ ] Separate list attached

Date	Problem	Date	Problem	Date	Problem

Family History

History of disease in family (blood relatives only):

Disease	Relation	Age diagnosed	Disease	Relation	Age diagnosed
[ ] Colon Cancer			[ ] Diabetes		
[ ] Breast Cancer			[ ] Heart Disease		
[ ] Ovarian Cancer			[ ] Stroke		
[ ] Prostate Cancer			[ ] High Cholesterol		
[ ] High Blood Pressure			[ ] Other		

Dallas Medical
Doctors of Internal Medicine

Vijaya Mummadi, M.D.

8210 Walnut Hill Ln., Ste 306, Dallas, TX 75231, Phone 214-306-4030, Fax: 214-242-6758

NEW PATIENT HISTORY - CONFIDENTIAL

Name: _____ **DOB:** _____

New drug allergies: _____ New surgeries: _____

Change in family history: _____

Social History

Smoking: Yes/No Number of packs per day: _____ [ ] Quit When? _____ Never Smoked _____
Number of alcoholic drinks/day on average: _____ Number of caffeinated drinks/day on average: _____

Drug abuse: Yes/ No

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Partnered

Occupation: _____

Residence: circle one: Home / Apartment / Assisted Living / Long Term Care / Memory Care

Do you exercise regularly? Yes/No Type(s) of activity: _____ Hours per week: _____

Memory impairment	Yes/No		
Hearing impairment	Yes/No	Hearing Aid	Yes/No
Snoring	Yes/No	Daytime sleepiness	Yes/No
Falls	Yes/No	Number of fall in 1 year: _____	
Gait/walking problem	Yes/No		
Assistance walking	Yes/No	If yes, circle one: cane / walker / wheel chair / power scooter	
Impaired daily activities	Yes/No	Assistance with daily activities	Yes/No
Do You Drive	Yes/No	Vision impairment	Yes/No

Living will/Advance directives Yes/No
Medical Power of Attorney Yes/No If yes: Name and contact information _____
DNR (Do not attempt resuscitation) Yes/No

Have you ever received a blood transfusion? Yes/No Do you have any tattoos? Yes/No
Do you have a carbon monoxide detector? Yes/No Do you wear a seat-belt? Yes/No

Sexual Health History

Sexual partners: Male [ ] Female [ ] Sexually transmitted infections: _____

Preventive Health History

Date of last bone density scan: _____ Date of last eye exam: _____
Date of last skin exam: _____ Date of last dental exam: _____
Date of last cardiac stress test: _____ Colorectal cancer screening: [ ] colonoscopy _____
[ ] stool for occult _____

Immunizations:

[ ] Flu Vaccine Date: _____ [ ] Shingles Vaccine
[ ] Pneumonia Vaccine Date: _____ [ ] Cervical Cancer Vaccine
[ ] Tetanus Vaccine Date: _____ [ ] Hepatitis B Vaccine

Women:

Number of pregnancies: ___ Number of miscarriages: ___
Date of last PAP smear: _____ Have you had an abnormal PAP smear? [ ] Yes [ ] No
Date of last mammogram: _____ Have you had an abnormal mammogram? [ ] Yes [ ] No
Do you perform regular self breast-exams? [ ] Yes [ ] No

Men:

Date of last rectal exam: _____ Have you had as abnormal PSA level? [ ] Yes [ ] No
Date of last PSA: _____ Do you perform regular self-testicular exams? [ ] Yes [ ] No

Patient Signature: _____ Date: _____