Dallas Medical Vijaya Mummadi, M.D., Rachel Jaison, FNP
Doctors of Internal Medicine
9900 N Central Expwy Ste 225(Glen Lakes Bldg) Dallas, TX 75231, Phone 469-646-8880, Fax: 469-646-8884

ANNUAL PATIENT HISTORY - CONFIDENTIAL

Name: ______________________________ **DOB:** _______________________

New drug allergies: _____________________ New surgeries: __________________________

Change in family medical history: ______________________________

Social History

Smoking/Tobacco use: 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: _____
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 resuscitate) 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/diabetic eye exam: _________
Date of last skin exam: _________ Date of last dental exam: _________
Date of last cardiac stress test: _________ Colorectal cancer screening: [ ] colonoscopy _____
Diabetic foot exam: ________ [ ] 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: ____________________

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ANNUAL WELLNESS VISIT

Annual Well Visits are considered preventive. Therefore, if there is a need to evaluate and manage a problem outside the scope of normal Annual Well Visit, an additional charge/office visit may be incurred. In case your concern needs to be addressed first and in order to avoid additional charges, we recommend that you change your visit to an acute or follow-up visit. Please inform the front desk about your visit change.

____
Signature of Patient

____
Print name

____
Date

Patient Name:______________________ Date: ____________

Change in address? : ____
Phone number: _________________________________
Email ID: ____

Please take a moment to answer these questions to better help us help you today.

1. **Have you seen any other doctor(s) since you were here last? If yes, what doctor and why?**

____

____

2. **Have you taken any new medications since your last appointment? If yes, what medication and why?**

____

____

3. **Do you need any refills today? No/Yes:** _______________________________

____

4. **What pharmacy would you prefer we transmit your prescription(s) refills?**

____

____

5. **Has there been any medical insurance? Yes/No**

____

____

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Do you see a specialist? If yes, please list below

Patient name:________________________________DOB _______________

Physician name and specialty	Phone number	Fax number

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The Alcohol Use Disorders Identification Test: Self-Report Version

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answerswill remain confidential so please be honest.
Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remem- ber what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10.Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	