McKinney Internal Medicine

ANNUAL PATIENT HISTORY - CONFIDENTIAL

Name: _____ **DOB:** _____

New drug allergies: _____ New surgeries: _____

Change in family 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 _____
Do you want to get resuscitated 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 active: Yes/No, Sexual partners: Male [ ] Female [ ], Sexually transmitted infections: _____

Preventive Health History dates:

Last bone density scan (DEXA): _____ Last eye exam/diabetic eye exam: _____
Last skin exam: _____ Last dental exam: _____
Last cardiac stress test: _____ Colorectal cancer screening: [ ] colonoscopy _____
Last diabetic foot exam: _____ [ ] stool for occult blood: _____

Immunizations dates:

[ ] Flu Vaccine: _____ [ ] Shingles Vaccine: _____
[ ] Pneumonia Vaccine: _____ [ ] Cervical Cancer Vaccine_____
[ ] Tetanus & whooping cough vaccine: _____ [ ] Hepatitis B Vaccine: _____

Women:

Number of miscarriages if any: _____
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: _____

McKinney Internal Medicine
Dr. Vijaya Mummadi, M.D., Rachel Jaison N.P.
8951 Collin McKinney Pkwy, Ste 301
McKinney, TX 75070
Phone: 214-556-0847 Fax: 214-556-0850

ANNUAL WELL 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

McKinney Internal Medicine
Dr. Vijaya Mummadi, M.D. ,Rachel Jaison N.P.
8951 Collin McKinney Pkwy, Ste 301
McKinney, TX 75070
Phone: 214-556-0847 Fax: 214-556-0850

Patient Name: _____ Date: _____
Contact Number: _____

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 change to address or medical insurance? Yes/No**
   _____
   _____

McKinney Internal Medicine
Dr. Vijaya Mummadi, M.D., Rachel Jaison N.P.
8951 Collin McKinney Pkwy, Ste 301
McKinney, TX 75070

Patient name: _____ DOB _____

List information about the Specialists you see

Physician name and specialty	Phone number	Fax number