Medical History

Please fill the information completely and to the best of your knowledge

Physician: Raj Dalal, M.D. Mauli Dalal M.D.	**Name:** (Last, First, M.I.)_____Pronouns:_____ DOB:_____Date Of Office Visit:_____ Previous Doctors: _____

Reason for Visit (Prioritize Concerns)	Duration	Reason for Visit (Prioritize Concerns)	Duration
1.		5.	
2.		6.	
3.		7.	
4.		8.	
Routine Visit/Annual Physical Examination/Refills	N/A	Date of last physical:	

Preventive Health Information

Event	M/Year	Event	M/Year
Mammogram (Women >50, 40 high risk)		Hep C (18-79) HIV screen (15-65)	
Last PAP smear (For women >21)		PSA (For men >55, optional)	
Osteoporosis test DEXA (For women high risk OR> 65)		Colonoscopy or other colon cancer screen (men and women > 45)	
Pneumonia Vaccine (>65 or high risk)		Aneurysm ultrasound (M 65-75 w tobacco history)	
Shingles Vaccine (For >50)		Tetanus/Td/TDAP Vaccine	

Past Medical History

Medical problem	Year	Medical problem	Year
Heart attack/Stent		Prediabetes or Diabetes	
Congestive Heart Failure		High Blood Pressure	
Irregular Heart		Asthma/Emphysema /COPD	
Cancer Location:_____		List other medical conditions: _____	
Pneumonia		Migraines	
Blood Transfusion		Stroke	
Hepatitis		Glaucoma	

Past Surgical Experience

Surgery/Procedure	Year	Surgery/Procedure	Year

Hospital Admissions

Hospital	Reason for admission	Year

Social History

Habit	Never	Current	Former	Quit year	Years of habit
Smoking		packs per day:			

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Alcohol		drinks per week:			
Other substances		Type:			
Local Pharmacy					
Mail Pharmacy (if any)					

Allergies

Medicine allergies	
Non medicinal allergies	

Medicine List

Name and dose of medicine	How many times a day	Name and dose of medicine	How many times a day
List over the counter meds/supplements			

Family History

	Mother	**Father**	**MGM**	**MGF**	**PGM**	**PGF**	**Sibling**	**Sibling**	**Sibling**
Alive/Died									
High Blood Pressure									
Diabetes Mellitus									
Heart Disease									
Stroke									
High Cholesterol									
Cancer (location if so)									
Asthma/ Emphysema									
Depression/Anxiety									
Autoimmune/Thyroid									
Other:_____									
Other:_____									

Other complaints or symptoms
(Mark "Yes" or "No")

Complaints	**Yes**	**No**	**Complaints**	**Yes**	**No**
Fever			Body aches		
Muscle aches			Weight Loss		
Sore Throat			Weight Gain		

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Excessive Appetite			Excessive Thirst		
Cough, Duration_____			Nose Bleeds		
Sputum , Color_____			Blood in sputum		
Sinus congestion or pain			Nose drainage		
Ear pain			Hearing Loss, Ringing in ear		
Heat intolerance			Cold intolerance		
Nodes or lumps in any part of the body			Excessive Fatigue Jaw pain Snoring heavily anyone observed you stop breathing during sleep?		
Chest pain **Constant/Intermittent** **Location_____** **On exertion/at rest** **Character of pain- (tightness, squeezing, burning, pressure)** **Radiation of pain to back, jaw, neck or arm**			Shortness Of Breath On Exertion At rest While sleeping at night Swollen Legs Palpitations		
Excessive Sweating			Blurred vision		
Headaches Duration____ One sided Both sided Throbbing			Loss of vision Are you bothered by light, sound or movements? Double vision		
Fatigue (Tiredness)			Memory loss		
Any weakness or paralysis			Any tingling or numbness		
At times sad/At times great					
Anxiety/Depression			Sleeplessness		
Lack of interest in things			Guilty or worthless feeling		
Suicidal thoughts			Agitation/Anger		
Poor appetite/Excessive eating			Excessive Sleepiness		
Lack of concentration			Unable to complete work		
Erectile Dysfunction			Low Libido		
Any other complaints to report					

Seizures or fits			Frequent falling		
Loss of sensation on skin			In-coordination		
Associated nausea or vomiting			Speech difficulty		
Dizziness					
Complaints	**Yes**	**No**	**Complaints**	**Yes**	**No**
Any episodes of confusion			Have you passed out any time in the past?		
Constipation			Diarrhea		
Blood in Stool			Dark, foul smelling stool		
Nausea/vomiting Heartburns Difficulty in swallowing Painful swallowing			Abdomen Pain Location_____ Type (Squeezing/ Burning/Cramp) Does it go to other		

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			locations?		
Joint pain			Backache		
Rash Duration___			Leg ulcers		
Varicose veins			Calluses		
<u>Breasts</u> Mass Discharge Tenderness/Pain Nipple inversion Color changes			<u>Urinary Problems</u> Incontinence Urgency Frequency Burning Blood in urine		
<u>Gynecological Issues</u> Menstruation: Regular/Irregular PMS symptoms: _____ Menopause symptoms:_____ Vaginal Discharge Vaginal Bleeding Vaginal itching Pain with sex Climacteric concerns Contraception: _____			<u>Skin</u> New moles Black moles Moles with changes Bleeding mole		

_____Signature (Patient/Medical Power of attorney)

Assessment/ Plan of Care: (Details in the -EMR records)

<u>Lifestyle Intake</u>

Brief overview of Typical Day schedule morning to night:

_____

Working? Y or N Occupation: _____ How many hours a week is work? _____

<u>Exercise and Movement:</u>

How often: _____ Duration:_____

Activities: _____ Any flexibility or mobility work? _____

Do you get your heart rate up? _____

If not active, what is something active you used to enjoy doing?_____

<u>Nutrition:</u>

Mostly home cooked? Y or N Some protein and veggies at each meal including breakfast? Y or N

Healthy fats at each meal? Y or N How many cups of vegetables a day? _____ How many cups of fruit? _____

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Typical day food recall: List everything you ate or drank in the past 24hr

Breakfast: _____

Lunch: _____

Dinner:_____

Snacks: _____

Drinks: _____

Any food sensitivities:_____

Sleep and Relaxation

Do you fall asleep easily? Y or N Do you stay asleep? Y or N If no, how often/how long do you wake up? _____

What time do you fall asleep? _____What time do you wake up? _____ Do you snore? Y or N

Do you use a CPAP? Y or N Do you feel rested upon awakening? Y or N Other sleeping aids? _____

Any relaxation practices?_____

Mood and Stress

Any past anxiety or depression? If yes, what treatments?_____

What are your main stressors? _____

What are your stress coping mechanisms or stress reduction practices?_____

Have you ever been abused, a victim of crime, or experienced a significant trauma? _____

Relationships and Support

Who do you live with? _____Are you sexually active (within past year)? Y or N

Who are your main supporters?_____ Do you have enough support? Y or N

Relationship or Sexual Health concerns: _____

Spiritual Health/Sense of Purpose

All versions of the same question, so pick one or two that speak to you:

What brings you joy? _____

What do you do to nurture your soul? Or what do you do to keep your soul alive?_____

Where do you find meaning and purpose in your life (how do you pursue this)?_____

When do you really feel alive or when in the past have you felt the most alive (and how are you going to cultivate this)? _____

Any known environmental toxin/chemical/mold exposures?_____

The 5 pillars of health, improved quality of life and prevention of chronic disease are: Sleep and Relaxation, Physical Activity, Nutrition, Stress Management, and Relationships.Prioritize by areas you would like to work on:

1_____2_____3_____4)_____5)_____

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