Mayur C. Patel, M.D., Inc.
Diplomate American Board of Internal Medicine

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Office: 818-843-5864

MEDICAL HISTORY

Date:_____

Name:_____ **Date of Birth:**_____

Allergies to Medications, X-Ray Dyes, or Other Substances:_____

Past Medical History: Please circle if you are *being or have been* treated for any of the following:

Arthritis	Asthma	Ulcers	Kidney Disease/Stones	Blood Clots
Diabetes	Pneumonia	Anemia	High Blood Pressure	Migraine
Cancer	Tuberculosis	Polyps	Gallbladder Disease	Gout
Heart Disease	Hay Fever	Liver Disease	Alcohol Abuse	Anxiety
Rheumatic Fever	Allergies	Thyroid Disease	Substance Abuse	Depression
HIV/AIDS	Hepatitis	Colitis	Skin Disease	Other_____
Blood Disorders			Venereal Diseases	

Have you ever had:

Stress Test Y N If yes, date_____
Flex Sig. Y N If yes, date_____
Endoscopy Y N If yes, date_____
Cardiac Cath Y N If yes, date_____
Colonoscopy Y N If yes, date_____

When was your last:

Cholesterol Check_____ Stool Check for Blood_____ Prostate Check_____

Review of Systems: Please circle if you are *currently* having any of the following:

General:

Weight Loss / Gain, Fever, Sleep Apnea, Loss of Appetite, Rash, Fatigue
Anxiety, Depression, Sleep Disturbance, Sleepiness During Daytime, Chills, Insomnia
Easy Bruising, Skin Lesions, Other_____

Neurological:

Headaches, Numbness, Changes in Hearing, Changes in Vision, Last Eye Exam_____
Tingling, Dizziness, Lightheadedness, Changes in Gait

Cardiovascular:

Chest Pain, Palpitations, Heart Murmur: Do you take antibiotics before dental exams? Y N
Shortness of Breath, Swollen Ankles

Respiratory:

Wheezing, Shortness of Breath, Nasal Discharge? Y N If yes, color_____
Painful Breathing, Cough? Productive? Y N If yes, color_____

Gastrointestinal:

Indigestion, Rectal Bleeding, Black / Tarry Stools, Change in Bowel Habits, Heartburn, Reflux
Abdominal Pain, Nausea, Vomiting, Hemorrhoids

Genitourinary:

Frequency, Burning with Urination, Getting up During the Night to Urinate
Urgency, Changes in Sex Drive, Incontinence: stress or urge
Erectile Dysfunction

Musculoskeletal:

Bone Pain, Joint Pain, Muscle Aches, Arthritis

Notes:_____

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Gynecologic and Obstetric History

Age at onset of periods:_____ Frequency:_____ Length of Periods:_____
Pregnancies:_____ Births:_____ Miscarriages:_____
Are you using birth control? Y N If yes, which method?_____

Do you have any of the following:

Prolonged Bleeding Abnormal Bleeding
Leakage of Urine Pelvic Pain Abnormal Discharge History of abnormal Pap Smear

When was your last: Pap Smear_____ Mammogram_____
Period_____ Breast Check_____ DEXA Scan (bone density)_____

Operations:_____

Hospitalizations(Other than for surgery):_____

Lifestyle

	Yes	No	
Do you wear seatbelts?	____	____	If no, why not?_____
Do you wear a bike helmet?	____	____	____n/a If no why not?_____
Do you exercise regularly?	____	____	If yes, type & duration per week_____
Do you smoke / chew tobacco?	____	____	If yes, how many packs per day?_____
Do you drink alcoholic beverages?	____	____	If you, how much per week?_____
Do you drink tea?	____	____	If you, how many cups per day?_____
Do you drink coffee?	____	____	If yes, how many cups per day?_____
Do you wish to be tested for AIDS?	____	____	
Do you have a living will?	____	____	
Have you had blood transfusions?	____	____	

Immunization History: Have you had any of the following?

Hepatitis A Y N Date:_____ Hepatitis B Y N Date:_____
Pneumovax Y N Date:_____ Flu Y N Date:_____
Tetanus Y N Date:_____ Other _____

Past Family History: Have any members of your family (parents, grandparents, & siblings) ever had any of the following?

Illness	Family Member(s)	Age Diagnosed
Cancer		
Hypertension (High Blood Pressure)		
Heart Disease		
Diabetes		
Strokes		
Mental Disease (Anxiety/Depression)		
Drug or Alcohol Addiction		
Glaucoma		
Bleeding Diseases		
Other:_____		

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Name:	DOB:	Date:

To better serve your healthcare needs, Mayur C. Patel, M.D., Inc. practice uses an electronic health record (EHR). This will not only include your chart contents, but your medication needs as well. Whether it is a one-time prescription or your daily medication, your prescriptions will be transmitted to your pharmacy with the EHR.

In order to meet your prescription needs, we ask that you provide us with your four (4) favorite pharmacies. Put the one you use the most at the top. This will ensure that your prescriptions are sent to the most convenient location for you to pick them up. Since we use the EHR, you may not receive a paper prescription.

Thank you for your information and cooperation in making this transition.

FAVORITE PHARMACY INFORMATION

Pharmacy name		
Pharmacy address	Street:	
	City:	
Pharmacy phone#		
Pharmacy fax # (if known)		
Pharmacy name		
Pharmacy address	Street:	
	City:	
Pharmacy phone#		
Pharmacy fax # (if known)		
Pharmacy name		
Pharmacy address	Street:	
	City:	
Pharmacy phone#		
Pharmacy fax # (if known)		
Pharmacy name		
Pharmacy address	Street:	
	City:	
Pharmacy phone#		
Pharmacy fax # (if known)		