SHALENDER MITTAL, M.D.
Adult Medicine Clinic of Blytheville
Blytheville, Arkansas

MEDICAL HISTORY FORM

Name_____

Confidential Record: Information contained here will not be released except when you have authorized us to do so. Your answers on this form will help us understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details. **Thank you.**

Main Concern Today:

_____
_____
_____

Have you seen Dr. Mittal before _____yes _____no

Your previous Physician's name _____

MEDICATIONS: List all prescriptions, over-the-counter medicines, birth control pills, herbs:

Medication Dosage Instructions

_____
_____
_____
_____
_____
_____

SURGICAL HISTORY: Please list all surgeries (with dates):

1. _____
2. _____
3. _____
4. _____

PERSONAL MEDICAL HISTORY:

Please indicate if you have had any medical problems (with dates) including but not limited to -
(Please put an **X** mark and indicate the date)

___ Heart disease _____
___ Heart attack _____
___ Diabetes _____
___ Thyroid problem, specify type _____
___ Cancer (Malignancy), specify type _____
___ Depression _____
___ Asthma _____
___ Seizures _____
___ Irregular heart rhythm _____
___ High blood pressure _____
___ High cholesterol _____
___ Kidney Disease _____
___ Stroke _____
___ Arthritis _____
___ COPD _____

Other problems (specify): _____

FAMILY HISTORY:

Please indicate the current status of your immediate family members:

	Alive	Deceased	Age (at death)	Any Medical Problems
Father:	___	____	_____	_____
Mother:	___	____	_____	_____
Sister:	___	____	_____	_____
Sister:	___	____	_____	_____
Brother:	___	____	_____	_____
Brother:	___	____	_____	_____

SOCIAL HISTORY & HABITS:

Marital Status: (circle one) MARRIED SINGLE DIVORCED WIDOWED

Smoking : ☐ Never ☐ Quit: Date Quit: _____

☐ Current Smoker : Packs/day _____ # of yrs _____

Alcohol Use: ☐ No ☐ Yes # drinks/week _____

Drug use: Do you use any recreational drugs ☐ No ☐ Yes

If yes, have you ever used needles ☐ No ☐ Yes

When were your most recent **HEALTH MAINTENANCE** screening tests?

Lipid (Cholesterol Screening) _____	Ever abnormal? _____	Details: _____
Mammogram _____	Ever abnormal? _____	Details: _____
Pap smear _____	Ever abnormal? _____	Details: _____
PSA (Prostate cancer screen) _____	Ever abnormal? _____	Details: _____
Colonoscopy _____	Ever abnormal? _____	Details: _____

LIST ALLERGIES and REACTIONS TO MEDICINES:

_____

_____

REVIEW OF SYMPTOMS: Please check (X) any current problems you have on the list below:

Constitutional
___ Fevers/chills/sweats
___ Unexplained weight loss/gain
___ Change in energy/weakness
___ Excessive thirst or urination

Eyes
___ Change in vision

Ears/Nose/Throat/Mouth
___ Difficult hearing/ringing in ears
___ Problems with teeth/gums
___ Hay fever/allergies

Cardiovascular
___ Chest pain/discomfort
___ Palpitations

Chest (breast)
___ Breast lump/nipple discharge

Respiratory
___ Cough/wheeze
___ Difficulty breathing

Gastrointestinal
___ Abdominal pain
___ Blood in bowel movement
___ Nausea/vomiting/diarrhea

Genitourinary
___ Nighttime urination
___ Leaking urine
___ Unusual vaginal bleeding
___ Discharge: penis or vagina

Musculo-skeletal
___ Muscle/joint pain

Skin
___ Rash/mole change

Neurological
___ Headaches
___ Dizziness/light-headedness
___ Numbness
___ Memory loss
___ Loss of coordination

Psychiatric
___ Anxiety/stress
___ Problems with sleep
___ Depression

Blood/Lymphatic
___ Unexplained lumps
___ Easy bruising/bleeding