Mount Vernon
INTERNAL MEDICINE

Date: _____

Patient Name: _____ **Date of Birth** _____ /_____/ _____

REASON FOR VISIT:

_____

_____

_____

_____

MEDICATIONS SUPPLEMENTS AND VITAMINS: (Please list the name, dosage and frequency of current medications)

	MEDICATION	DOSAGE	FREQUENCY (HOW OFTEN)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

☐ Patient brought in Medication List ☐ Patient brought in Medications

Allergies: _____

NEW PATIENT INTAKE FORM

Patient Name: _____ **Date of Birth** _____ /_____/_____

PAST MEDICAL HISTORY: (Please check box and put date diagnosed)

☐ High Blood Pressure _____ ☐ Arthritis_____ ☐ Thyroid Disease (please specify) _____

☐ High Cholesterol _____ ☐ Kidney Disease _____ ☐ Heart Disease (please specify) _____

☐ Diabetes_____ ☐ Asthmas _____ ☐ Cancer (please specify) _____

☐ Stroke _____ ☐ Osteoporosis_____ ☐ Clotting disorder (please specify) _____

☐ Other: _____

PAST SURGICAL HISTORY: (Please list any surgical procedures, hospitalizations and their dates)

NAME	DATE

SOCIAL HISTORY

Do you currently smoke or chew tobacco? ☐ Yes ☐ No

If yes, how long have you smoked? _____

How much do you smoke per day? _____

Do you currently drink alcohol? ☐ Yes ☐ No

How much do you drink? _____

Do you feel like you need to cut back?_____

If you smoked previously, how long did you smoke, how much per day and when did you quit?

_____

Do you exercise regularly? ☐ Yes ☐ No If yes, how often and for how long do you exercise? _____

Have you used illicit drugs? ☐ Yes ☐ No If yes, what have you used?_____

Do you desire STD Screening? ☐ Yes ☐ No

FAMILY HISTORY (Please list below blood relatives that have a history of the following:)

Established patients Add only new changes in last 12 - 18 months

(☑ boxes that apply)	Living	Deceased	Age / Age at Death	Stroke	Hypertension	Kidney Disease	Heart Disease	Diabetes	Cancer	Type of Cancer	Other (Please list)
Mother											
Father											
Siblings											
Grandmothers	Maternal										
	Paternal										
Grandfathers	Maternal										
	Paternal										
Children											

NEW PATIENT INTAKE FORM

Patient Name: _____ **Date of Birth** _____ /_____/_____

PLEASE FILL IN DATE OF YOUR LAST:

Colonoscopy/Cologuard		Flu shot (Regular/High Dose)		Pneumonia shot (Prevnar 13)	
Mammogram		Tetanus shot		COVID shot	
Bone Density		Shingrix shot			
Pap Smear		Pneumonia shot (Pneumovax 23)			
First day of last menstrual cycle:		Pneumonia shot (Prevnar 20)			

REVIEW OF SYSTEMS (Please circle all that apply <u>within the last 30 days</u>)

GENERAL
Weight Change
Fever
Fatigue
Difficulty Sleeping

Head & Neck
Visual Changes (Not Glasses)
Double Vision
Sinus Problems
Trouble Hearing
Ringing in Ears
Hoarseness
Persistent sore throat
Mouth Sores
Swollen Glands (frequent)

RESPIRATORY/LUNGS
Stop breathing during sleep
Shortness of breath
Wheezing
Coughing up blood
Snoring

Heart/Vascular
Chest pain/tightness
Irregular rapid heart beat
Ankle swelling

STOMACH/BOWEL
Black/Bloody Stools
Nausea/Vomiting (Frequent)
Frequent Heart Burn/Acid (GERD)
Abdominal pain
Diarrhea (Frequent)
Constipation
Difficulty swallowing
Vomiting blood

KIDNEY/BLADDER
Urinary Incontinence
Urinary hesitancy
Frequent urination
Urinary urgency
Painful urination/dysuria

REPRODUCTION
Inability to have an erection
Painful Intercourse
Decreased sexual desire
Sexually Transmitted Diseases

WOMEN
Breast pain/lumps
Frequent sweats/Hot flashes
Menopause
Menstrual problems
Pelvic Pain
Pregnancy problems
Vaginal discharge

SKELETAL
Back pain (major)
Neck pain (major)
Joints swelling/Stiffness
Left leg pain
Right leg pain

NEURO
Numbness or tingling
Severe frequent headaches
Forgetfulness/Confusion
Weakness
Headache

SKIN & HAIR PROBLEMS
Changes in hair/hair loss
Persistent rash
Changes in moles

PSYCH/SOCIAL
Feeling blue/discouraged
High anxiety/stress