Mount Vernon
INTERNAL MEDICINE

Greenway ID # _____ **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 ☐ Medication List Reviewed by MA

Allergies: _____

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:)

(☑ boxes that apply)	Living	Deceased	Age / Age at Death	Stroke	Hypertension	Kidney Disease	Heart Disease	Diabetes	Cancer	Other (Please list)
Mother										
Father										
Siblings										
Grandmothers										
Grandfathers										
Aunts										
Uncles										
1st Cousins										
Children										

PATIENT INTAKE FORM

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

PLEASE FILL IN DATE OF YOUR LAST:

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

REVIEW OF SYSTEMS (Please verify if you have had any of the following <u>within the last 30 days</u>)

Please circle all that apply and explain

CONSTITUTIONAL

Fever	YES	NO	_____
Weight Loss	YES	NO	_____
Difficulty Sleeping	YES	NO	_____
Fatigue	YES	NO	_____
Weight Gain	YES	NO	_____
Dehydration	YES	NO	_____
Headache	YES	NO	_____

EYES

Changes in Vision	YES	NO	_____
Far-Sightedness	YES	NO	_____
Near-Sightedness	YES	NO	_____
Total Vision Loss	YES	NO	_____
Eye Pain	YES	NO	_____

EARS, NOSE, MOUTH, AND THROAT

Loss of Hearing	YES	NO	_____
Cold Symptoms	YES	NO	_____
Ringing in Ears	YES	NO	_____
Hoarseness	YES	NO	_____
Sneezing Spells	YES	NO	_____
X-Ray Exposure to Tonsils, Adenoids, Thymus, or Face	YES	NO	_____

BREASTS

Lumps	YES	NO	_____
Nipple Discharge	YES	NO	_____
Tenderness	YES	NO	_____
Abnormal Changes in Breast Size	YES	NO	_____

RESPIRATORY

Wheezing	YES	NO	_____
Dry Cough	YES	NO	_____
Shortness of Breath	YES	NO	_____
Productive Cough	YES	NO	_____

CARDIOVASCULAR

High Blood Pressure	YES	NO	_____
Heart Trouble	YES	NO	_____
Palpitations	YES	NO	_____
Edema (swelling)	YES	NO	_____
Chest Pain	YES	NO	_____

GASTRONINTESTINAL

Abdominal Pain	YES	NO	_____
Vomiting	YES	NO	_____
Nausea	YES	NO	_____
Blood in Stool	YES	NO	_____
Tarry or Black Stool	YES	NO	_____
Hemorrhoids	YES	NO	_____
Hernias	YES	NO	_____
Heartburn	YES	NO	_____
Diarrhea/Loose Stools	YES	NO	_____
Mucus in Stool	YES	NO	_____
Loss of Appetite	YES	NO	_____
Bloating	YES	NO	_____
Constipation	YES	NO	_____
Excessive Belching	YES	NO	_____
Changes in Bowel Habits	YES	NO	_____

GENITOURINARY

Difficulty Urinating	YES	NO	_____
Sexually Transmitted Infections	YES	NO	_____
Incontinence	YES	NO	_____
Kidney Trouble	YES	NO	_____
Irregular Periods	YES	NO	_____
Erectile Dysfunction	YES	NO	_____

NEUROLOGIC

Dizziness	YES	NO	_____
Fainting	YES	NO	_____
Muscular Weakness	YES	NO	_____
Tingling or Numbness	YES	NO	_____
Seizures	YES	NO	_____
Nervous Disorders	YES	NO	_____

MUSCULOSKELETAL

Joint Pain	YES	NO	_____
Joint Swelling	YES	NO	_____
Reddish Coloring at Joints	YES	NO	_____
Stiffness	YES	NO	_____
Muscle Pain	YES	NO	_____
Muscular Weakness	YES	NO	_____
Back Pain	YES	NO	_____
Arm Pain	YES	NO	_____
Leg Pain	YES	NO	_____
Leg Cramps	YES	NO	_____
Urge to Move Legs	YES	NO	_____

ENDOCRINE

Thyroid Disease	YES	NO	_____
Diabetes Mellitus	YES	NO	_____

PSYCHIATRIC

Depressive Symptoms	YES	NO	_____
Anxiety	YES	NO	_____
Psychosis	YES	NO	_____
Hallucinations	YES	NO	_____

ALLERGIC-IMMUNOLOGIC

Sinus Allergy Symptoms	YES	NO	_____
Allergic Dermatitis	YES	NO	_____