Premier Internal Medicine of Alpharetta, PC

Patient Information

Date ___/___/___

First Name _____Middle Initial____ Last Name_____

Date of Birth ___/___/___ Social Security #_____ Gender ____Male ____Female

Marital Status ____Single ____Married ____Separated ____Divorced ____Widowed

Address_____Apt #_____

City_____ State ____ Zip Code_____

Home Phone_____ Cell Phone _____ Work Phone_____

Race & Ethnicity_____ Primary Language_____

Employment Status ___Employed ___Self-Employed ___Unemployed ___Disabled ___Retired ____Student

Occupation _____ Email Address _____

Emergency Contact (Name, Relationship, Phone)

_____

PHARMACY INFORMATION

Name_____ Pharmacy Phone #_____

Pharmacy Address _____

INSURANCE INFORMATION

Primary Insurance Company_____ Phone #_____

ID/Subscriber # _____ Group # _____

Subscriber Name _____Relationship to patient _____

Subscriber SSN _____ Subscriber DOB _____

Secondary Insurance Company_____ Phone #_____

ID/Subscriber # _____ Group # _____

Name	DOB:

Current Medications

Please include all Prescription, Over the Counter, Herbal Medications & Supplements.

Medication	Dose	Frequency

Allergies? Yes or No
Please list all medications AND reactions.

1.	**3.**
2.	**4.**

Past Medical History

Please list diagnosis (i.e. Diabetes, Hypertension, ect.), age/year at time of diagnosis.

1.	**5.**
2.	**6.**
3.	**7.**
4.	**8.**

Past Surgical History

1.	**5.**
2.	**6.**
3.	**7.**
4.	**8.**

Family History

Father ○ **Alive, age _____** ○ **Deceased, age _____** **Cause of Death** **_____**	○ High Blood Pressure ○ High Cholesterol ○ Diabetes ○ Heart Disease _____ ○ Stroke ○ Prostate Cancer ○ Testicular Cancer ○ Colon Cancer ○ Other _____ ○ _____
Mother ○ **Alive, age _____** ○ **Deceased, age _____** **Cause of Death** **_____**	○ High Blood Pressure ○ High Cholesterol ○ Diabetes ○ Heart Disease _____ ○ Stroke ○ Breast Cancer ○ Cervical Cancer ○ Ovarian Cancer ○ Colon Cancer ○ Other _____ ○ _____
Siblings **# of Brothers _____** **# of Sisters _____**	○ High Blood Pressure ○ High Cholesterol ○ Diabetes ○ Heart Disease _____ ○ Stroke ○ Breast Cancer ○ Cervical Cancer ○ Ovarian Cancer ○ Colon Cancer ○ Prostate Cancer ○ Testicular Cancer ○ Other _____ ○ _____
Children **# of Sons _____** **# of Daughters _____**	○ _____ ○ _____

REVIEW OF SYSTEMS

CONSTITUTIONAL
- CHANGES IN APPETITE
- NIGHT SWEATS
- FEVER/CHILLS
- RECENT WEIGHT LOSS/GAIN
- FATIGUE

CARDIOVASCULAR
- CHEST PAIN
- PALPITATIONS
- FAINTING
- DIFFICULTY BREATHING WHEN LAYING FLAT
- LEG SWELLING
- LEG PAIN WHEN WALKING

NEUROLOGICAL
- HEADACHES
- NUMBNESS
- TINGLING

SKIN
- CHANGE IN EXISTING SKIN LESION
- NEW RASH
- NEW SKIN LESION

RESPIRATORY
- WHEEZING
- SHORTNESS OF BREATH
- COUGH
- COUGHING UP BLOOD

PSYCHIATRIC
- ANXIETY
- DEPRESSION
- INSOMNIA

EYES
- RECENT VISION CHANGES
- DOUBLE VISION
- EYE PAIN
- EYE EXAM
- _____

GASTROINTESTINAL
- HEARTBURN
- CONSTIPATION
- CHRONIC DIARRHEA
- CHANGE IN BOWEL HABITS
- NAUSEA/VOMITING
- BLOOD IN STOOL

WOMEN'S HEALTH
- HEAVY/IRREGULAR PERIODS
- BREAST LUMPS/NIPPLE DISCHARGE
- MENOPAUSE
- PAINFUL SEXUAL INTERCOURSE
- POSTMENOPAUSAL BLEEDING

EAR, NOSE, THROAT
- LOSS OF HEARING
- SNORING
- TROUBLE SWALLOWING
- DENTAL EXAM
- _____

GENITOURINARY
- BLOOD IN URINE
- URINARY INCONTINENCE
- OVERACTIVE BLADDER

MEN ONLY
- ERECTILE DYSFUNCTION
- TESTICULAR PAIN/MASS
- WEAK STREAM

ALLERGY/IMMUNOLOGY
- SEASONAL ALLERGIES
- FOOD ALLERGIES

ENDOCRINE
- HEAT INTOLERANCE
- COLD INTOLERANCE
- EXCESSIVE URINATION
- DIMINISHED SEX DRIVE

HEMATOLOGIC/LYMPHATIC
- EASY BRUISING
- ENLARGED LYMPH NODES

MUSCULOSKELETAL
- JOINT PAIN, REDNESS, SWELLING
- MUSCLE PAIN

Social History	
Marital Status	**Single Engaged Married Separated Divorced Widowed**
Occupation	
Are you sexually active?	**Yes No** **Men Women Both**
Tobacco Use **Yes or No**	**If Current Smoker:** **___# Packs Per Day ____Years** **If Former Smoker:** **___# Packs Per Day _____Years** **Quit Date_____**
Alcohol Use **Yes or No**	**If yes, how much and how often?** **_____**
Illicit Drug Use	

Healthcare Maintenance Please list date of exam/procedure, performing physician, practice and location.	
Mammogram	____/____
PAP Smear	____/____
Bone Density	____/____
Colonoscopy	____/____
Prostate/Rectal Exam	____/____

Immunizations	
Influenza (Flu)	____/____
Gardasil (HPV)	____/____
Hepatitis B	____/____, ____/____, ____/____
Tetanus/Tdap (every 10 years)	____/____
Pneumovax 23	____/____
Prevnar 13	____/____
MMR (Measles/Mumps/Rubella)	____/____
Zostavax or Shingrix (Shingles)	____/____