INTERNAL MEDICINE CENTER, LLC
101 Memorial Hospital Drive, Suite 200, Mobile, AL 36608 P.O. Drawer 160928, Mobile, AL 36616
www.internalmedicinecenter.org 251-414-5900

Name:_____ Date of Birth:_____

Reason for visit:_____

_____

Please check any symptoms that you have recently experienced:

____ Fatigue	____ Hearing Loss	____ Diarrhea	____ Heath Intolerance
____ Weigh Loss	____ Ringing in Ears	____ Heart Burn	____ Cold Intolerance
____ Fever	____ Chest Pain	____ Menstrual Problem	____ Bleeding
____ Chills	____ Swelling	____ Urinary Burning	where?_____
____ Night Sweats	____ Short of Breath	____ Frequent Urnination	____ Rash/Itching
____ Visual Changes	____ Heart Flutters	____ Anxiety	____ Muscle Weakness
____ Eye Pain	____ Muscle Cramps	____ Depression	____ Slurred Speech
____ Red Eye	____ Cough	____ Joint Pain	____ Numbness
____ Headache	____ Wheezing	Where?_____	____ Tremor
____ Hoarseness	____ Sleepiness in day	____ Back Pain	Short of Breath:
____ Sore Throat	____ Abdominal Pain	____ Bruising	____ at rest
____ Nose Bleeds	____ Blood in Stool	____ Swollen Glands	____ with exercise
____ Sinus Trouble	____ Nausea/Vomitting	____ Excess hunger/thirst	____ while lying down

Please list any changes in your medical history since your last visit:

_____

_____

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Please list medications/dosages:

_____

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Date of last Pap smear:_____
Date of last Mammogram:_____
Date of last PSA:_____
Date of last Colonoscopy:_____

Allergies:_____

_____

Date:_____