INTERNAL MEDICINE CENTER, LLC

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Name:______________________________ Date:____________________

1. What medical problems are you here for?

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2. What new symptoms are you having?

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3. Have you ever had a stroke, kidney disease, liver disease, or cancer?____________________

4. Do you have hypertension, heart disease, or diabetes?____________________

5. What surgeries have you had?____________________

6. Please circle any problems you are having:

Rash	Chest Pains	Sores__________
Frequent Bleeding	Excessive Bleeding	Pain__________
Ear Problems	Blurred Vision	Numbness__________
Fever	Nausea	Tingling__________
Heartburn	Diarrhea	Swelling__________
Abdominal Pain	Seizure	
Weight Gain	Painful Urination	
Weight Loss	Short of Breath	
Blood in Stool	Sexual Problems	
Wheezing	Cough	

7. Last menstrual period?____________________

8. Do you smoke?__________ How much?____________________

9. Do you drink?__________ How much?____________________

10. Marital Status?____________________

11. Place of employment?____________________

12. What medicines do you take? Do you need refills? YES or NO ____________________

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13. Allergies:____________________

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