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 _____

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, etc.), age/year at time of diagnosis.

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

Past Surgical History

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

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 ○ Skin Cancer ○ Other _____
Mother ○ **Alive, age _____** ○ **Deceased, age _____** **Cause of Death** **_____**	○ High Blood Pressure ○ High Cholesterol ○ Diabetes ○ Heart Disease ○ Stroke ○ Breast Cancer ○ Cervical, Ovarian or Uterine Cancer ○ Colon Cancer ○ Skin Cancer ○ Other _____
Paternal Grandfather **Paternal Grandmother** **Maternal Grandfather** **Maternal Grandmother** **# Of Brothers _____** **# Of Sisters _____** **# Of Sons _____** **# Of Daughters _____**	○ _____ ○ _____ ○ _____ ○ _____ ○ _____ ○ _____ ○ _____ ○ _____

REVIEW OF SYSTEMS

CONSTITUTIONAL
- CHANGE IN APPETITE
- FATIGUE
- WEIGHT GAIN
- WEIGHT LOSS

CARDIOVASCULAR
- CHEST PAIN
- PALPITATIONS
- FAINTING
- LEG SWELLING
- LEG PAIN WHEN WALKING

NEUROLOGICAL
- HEADACHES
- NUMBNESS
- TINGLING
- DIZZINESS

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

RESPIRATORY
- COUGH
- SHORTNESS OF BREATH
- WHEEZING

PSYCHIATRIC
- ANXIETY
- DEPRESSION
- INSOMNIA

EYES
- RECENT VISION CHANGES
- EYE PAIN
- EYE EXAM

_____

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

WOMEN'S HEALTH
- HEAVY PERIODS
- IRREGULAR PERIODS
- BREAST LUMP
- MENOPAUSE
- PAINFUL SEXUAL INTERCOURSE
- POSTMENOPAUSAL BLEEDING

EAR, NOSE, THROAT
- DIFFICULTY 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 THIRST

HEMATOLOGIC/LYMPHATIC
- EASY BRUISING
- ENLARGED LYMPH NODES

MUSCULOSKELETAL
- JOINT PAIN OR SWELLING
- MUSCLE PAIN

Social History	
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	____/____

Immunizations	
Influenza (Flu)	____/____
Gardasil (HPV)	___/___, ___/___, ___/___
Hepatitis B	___/___, ___/___, ___/___
Tetanus/Tdap (every 10 years)	___/___
Pneumovax 23	___/___
Prevnar 13	___/___
MMR (Measles/Mumps/Rubella)	___/___
Zostavax or Shingrix (Shingles)	___/___, ___/___
COVID-19	___/___, ___/___