

Premier Internal Medicine of Alpharetta, PC

Patient Information

Date ___/___/___ **Preferred Contact Method:** Phone Email Text
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 DOB _____
Secondary Insurance Company _____ Phone # _____
ID/Subscriber # _____ Group # _____
Subscriber Name _____ Relationship to patient _____
Subscriber DOB _____

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Family History

<p>Father</p> <ul style="list-style-type: none"> <input type="radio"/> Alive, age _____ <input type="radio"/> Deceased, age _____ Cause of Death _____ 	<ul style="list-style-type: none"> <input type="radio"/> Blood Disorder <input type="radio"/> Cancer: _____ <input type="radio"/> Diabetes <input type="radio"/> Heart Attack <input type="radio"/> High Blood Pressure <input type="radio"/> High Cholesterol <input type="radio"/> Kidney or Liver Disease <input type="radio"/> Lung Disease (Asthma/COPD) <input type="radio"/> Stroke <input type="radio"/> Thyroid Disease
<p>Mother</p> <ul style="list-style-type: none"> <input type="radio"/> Alive, age _____ <input type="radio"/> Deceased, age _____ Cause of Death _____ 	<ul style="list-style-type: none"> <input type="radio"/> Blood Disorder <input type="radio"/> Cancer: _____ <input type="radio"/> Diabetes <input type="radio"/> Heart Attack <input type="radio"/> High Blood Pressure <input type="radio"/> High Cholesterol <input type="radio"/> Kidney or Liver Disease <input type="radio"/> Lung Disease (Asthma/COPD) <input type="radio"/> Stroke <input type="radio"/> Thyroid Disease
<p>Paternal Grandfather Paternal Grandmother Maternal Grandfather Maternal Grandmother</p> <p>Paternal Uncle</p> <p>Paternal Aunt</p> <p>Maternal Uncle</p> <p>Maternal Aunt</p>	<p>Indicate any major health diagnoses:</p> <ul style="list-style-type: none"> <input type="radio"/> _____ <input type="radio"/> _____ <input type="radio"/> _____ <input type="radio"/> _____ <input type="radio"/> _____ <input type="radio"/> _____ <input type="radio"/> _____ <input type="radio"/> _____
<p># of Sons _____</p> <p># of Daughters _____</p>	<ul style="list-style-type: none"> <input type="radio"/> _____ <input type="radio"/> _____

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<p>Brother</p> <ul style="list-style-type: none"><input type="radio"/> Alive, age _____<input type="radio"/> Deceased, age _____ Cause of Death _____ <p>Brother</p> <ul style="list-style-type: none"><input type="radio"/> Alive, age _____<input type="radio"/> Deceased, age _____ Cause of Death _____ <p>Half Brother</p> <ul style="list-style-type: none"><input type="radio"/> Alive, age _____<input type="radio"/> Deceased, age _____ Cause of Death _____	<p>Indicate any major health diagnoses:</p> <ul style="list-style-type: none"><input type="radio"/> _____<input type="radio"/> _____ <input type="radio"/> _____<input type="radio"/> _____ <input type="radio"/> _____<input type="radio"/> _____
<p>Sister</p> <ul style="list-style-type: none"><input type="radio"/> Alive, age _____<input type="radio"/> Deceased, age _____ Cause of Death _____ <p>Sister</p> <ul style="list-style-type: none"><input type="radio"/> Alive, age _____<input type="radio"/> Deceased, age _____ Cause of Death _____ <p>Half Sister</p> <ul style="list-style-type: none"><input type="radio"/> Alive, age _____<input type="radio"/> Deceased, age _____ Cause of Death _____	<p>Indicate any major health diagnoses:</p> <ul style="list-style-type: none"><input type="radio"/> _____<input type="radio"/> _____ <input type="radio"/> _____<input type="radio"/> _____ <input type="radio"/> _____<input type="radio"/> _____

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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

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Social History	
Are you sexually active?	Yes No
Tobacco Use Yes or No	Men Women Both 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	___/___
Prennar 13	___/___
MMR (Measles/Mumps/Rubella)	___/___
Zostavax or Shingrix (Shingles)	___/___, ___/___
COVID-19	___/___, ___/___
RSV	___/___