



# Internal Medicine Intake Form

Room #: \_\_\_\_\_  
Checked in by: \_\_\_\_\_  
Time: \_\_\_\_\_

Date: \_\_\_\_\_  
Name: \_\_\_\_\_  
MRN: \_\_\_\_\_

Best # to contact: \_\_\_\_\_

PCP: \_\_\_\_\_

**Chief Complaint:**

\_\_\_\_\_

Age: \_\_\_\_\_ HT: \_\_\_\_\_ WT: \_\_\_\_\_ Smoker: Y / N

BP: \_\_\_\_\_ P: \_\_\_\_\_ T: \_\_\_\_\_ R: \_\_\_\_\_ Diabetic: Y / N

Glucose: \_\_\_\_\_ Pulse Ox: \_\_\_\_\_ Peak Flow: \_\_\_\_\_

Allergies: Y / N, Specify: \_\_\_\_\_ Latex Allergy: Y / N

Medications updated in Dr. First: Y / N Refills forwarded in Dr. First: Y / N

Pharmacy information updated: Y / N

OTC/Herbal Medications : \_\_\_\_\_

Pain: Y / N If yes, pain score: \_\_\_\_\_

LMP: \_\_\_\_\_ Pregnant: Y/N (If yes, refer per protocol)

School/Work Note Needed: Y / N Forms Completed: 1 / 2 pages

**Preventive Health Services**

(Circle if needed)

Mammogram: \_\_\_\_\_  
(If due, complete pink form)

Pap Smear: \_\_\_\_\_

Chlamydia: \_\_\_\_\_  
(If due, complete pink form)

T- dap; Td: \_\_\_\_\_

Pneumococcal Vaccine: \_\_\_\_\_

Influenza vaccine: \_\_\_\_\_

Colonoscopy: \_\_\_\_\_

Bone Density: \_\_\_\_\_

SAMPLE

cbc	LYTES	CHOL	Ha1c	Lipid prof
U/A	PSA	TSH	Ob x 3	Alb/Cr

HEENT

Neck

Lungs

CV

Abdomen

Extremities

Neuro

Dictated: Y / N

Billing Level: \_\_\_\_\_

Diagnostic Code(s): \_\_\_\_\_

Staff Chaperone: \_\_\_\_\_