Rockville Internal Medicine **Patient Intake Form**

Date: _____ **"PLEASE PRINT"**

(mark preferred # with a *)

PATIENT NAME: _____ Home Phone # :_____
LAST FIRST MI Cell Phone#:_____
Work Phone #:_____

NICKNAME: _____ Date of Birth:_____
ADDRESS: _____ Gender: Male Female
_____ Married: Yes No
_____ Children: Yes No
E-MAIL: _____

Emergency Contact Name:_____ Phone #:_____
Relationship to Patient:_____

Reason for Visit:_____
Referred By: _____

MEDICAL PROBLEMS (past or current) e.g.: heart attack, high cholesterol, stroke, arthritis, depression, anemia, asthma, pain, diabetes, etc.

_____
_____
_____

SURGERIES (include year) e.g.: appendix, tonsils, heart bypass, knee surgery, etc.

_____
_____
_____

CURRENT MEDICATIONS TAKEN (prescription and over the counter include dose):

Drug Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Name_____ Date of Birth_____

ALLERGIES TO MEDICATIONS: No Yes, please fill in blanks below:

Medication:_____ Reaction:_____
Medication:_____ Reaction:_____
Medication:_____ Reaction:_____

OTHER DOCTORS OR SPECIALISTS YOU SEE:

Name:_____ Specialty:_____ Last Visit:_____
Name:_____ Specialty:_____ Last Visit:_____
Name:_____ Specialty:_____ Last Visit:_____
Name:_____ Specialty:_____ Last Visit:_____

HEALTH MAINTENANCE: When was your last?

Physical_____ Cholesterol Blood Test_____
Colonoscopy_____ Bone Density Test_____
Upper Endoscopy_____ Tetanus Shot_____
Pneumonia Vaccine_____

Males: Prostate Blood Test (PSA)_____
Females: PAP/Pelvic Exam_____ Mammogram_____

DO YOUR PARENTS OR SIBLINGS HAVE ANY MEDICAL PROBLEMS?

_____
_____
_____

DO ANY OTHER MEDICAL PROBLEMS RUN IN YOUR FAMILY? e.g. cancer, heart attack, colon cancer, etc.

_____
_____
_____

DO YOU SMOKE? NO YES FORMERLY

Maximum packs per day_____ Number of Years_____ When Quit _____

DO YOU DRINK ALCOHOL? YES NO If yes, how many drinks per week?_____

DO YOU USE ANY OTHER DRUGS? YES NO If yes, what?_____

DO YOU HAVE? (circle) LIVING WILL DNR ORDER ADVANCED DIRECTIVES

HOW WOULD YOU LIKE TO BE CONTACTED WITH TEST RESULTS, LABS, ETC.?

Telephone #_____ May we leave a message on a machine? YES NO
May we leave a message with a spouse or relative? YES NO

Patient Signature_____ Date_____
OR
Guardian Signature_____ Date_____