continuum
INTERNAL MEDICINE

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Established Patient Form

Today's Date:_____
_____/_____/_____

_____ _____
Last Name **First Name** **DOB**

Has there been any changes since your last office visit?

- Medications Yes (please list)_____ No
- Medical Diagnosis Yes (please list)_____ No
- Allergies Yes (please list)_____ No
- Surgeries or hospitalizations Yes (please list)_____ No
- Family History Yes (please list)_____ No
- Immunizations Yes (please list)_____ No
- LMP Yes (please list)_____ No
- Updated Pharmacy Yes (please list)_____ No

Do you currently have any of the following symptoms today? **-OR-** None

General/Constitutional

☐ Change in appetite ☐ Fever ☐ Night Sweats ☐ Weight gain

Ophthalmologic

☐ Blurred vision ☐ Eye pain ☐ Itching and redness

ENT

☐ Decreased hearing ☐ Nosebleed ☐ Snoring ☐ Ear pain ☐ Sore throat ☐ Runny nose

Endocrine

☐ Cold intolerence ☐ Excessive thrist ☐ Heat intolerence ☐ Weight loss ☐ Swollen glands

Respiratory

☐ Cough ☐ Shortness of breath ☐ Wheezing

Cardiovascular

☐ Chest pain ☐ Fluid accumulation in the legs ☐ Irregular heartbeat ☐ Palpitations

Gastrointestinal

☐ Abdominal pain ☐ Blood in stool ☐ Constipation ☐ Diarrhea ☐ Nausea ☐ Vomitting

Genitourinary

☐ Blood in urine ☐ Difficulty urinating ☐ Frequent urination ☐ Painful urination

Musculoskeletal

☐ Back/Neck problems ☐ Painful joint ☐ Weakness ☐ Muscle aches

Skin

☐ Dry skin ☐ Itching ☐ Rash

Neurologic

☐ Dizziness ☐ Headaches ☐ Memory loss ☐ Tingling/Numbness

Psychological

☐ Anxiety ☐ Depressed mood