Mount Vernon
INTERNAL MEDICINE

Date: _____

Patient Name: _____ **Date of Birth** _____ /_____/_____

REASON FOR VISIT:

_____

MEDICATION, VITAMINS AND SUPPLEMENTS REVIEW

Please follow instructions below:

You can access and print your medication list from the patient portal. Make notes to Add/Remove updates and attach to this form. If unable to access the portal, write a clearly written list of all medications, vitamins and supplements with **Name, Dosage and Frequency** of each item. Please bring this form and list to your appointment.

PAST MEDICAL SURGICAL HISTORY: (Add only changes in the last 12 months)

_____

_____

_____

SOCIAL HISTORY

Do you currently smoke or chew tobacco? ☐ Yes ☐ No

If yes, how long have you smoked? _____

How much do you smoke per day? _____

Do you currently drink alcohol? ☐ Yes ☐ No

How much do you drink? _____

Do you feel like you need to cut back?_____

If you smoked previously, how long did you smoke, how much per day and when did you quit?

_____

Do you exercise regularly? ☐ Yes ☐ No

If yes, how often and for how long do you exercise? _____

Have you used illicit drugs? ☐ Yes ☐ No

If yes, what have you used?_____

Do you desire STD Screening? ☐ Yes ☐ No

FAMILY HISTORY (Please list below blood relatives that have a history of the following:)

Add only changes in last 12 months

(☑ Indicate Relationship)	Living	Deceased	Age / Age at Death	Stroke	Hypertension	Kidney Disease	Heart Disease	Diabetes	Cancer	Type of Cancer	Other (Please list)

PLEASE FILL IN DATE OF YOUR LAST:

Colonoscopy/Cologuard		Flu shot (Regular/High Dose)		Pneumonia shot (Prevnar 13)	
Mammogram		Tetanus shot		COVID shot	
Bone Density		Shingrix shot			
Pap Smear		Pneumonia shot (Pneumovax 23)			
First day of last menstrual cycle:		Pneumonia shot (Prevnar 20)			

ESTABLISHED PATIENT INTAKE FORM

Patient Name: _____ **Date of Birth** _____ /_____/_____

REVIEW OF SYSTEMS (Please circle all that apply within the last 30 days)

GENERAL

Weight Change

Fever

Fatigue

Difficulty Sleeping

HEAD & NECK

Visual Changes (Not Glasses)

Double Vision

Sinus Problems

Trouble Hearing

Ringing in Ears

Hoarseness

Persistent Sore Throat

Mouth Sores

Swollen Glands (frequent)

RESPIRATORY/LUNGS

Stop Breathing During Sleep

Shortness of Breath

Wheezing

Coughing up Blood

Snoring

HEART/VASCULAR

Chest Pain/Tightness

Irregular Rapid Heart Beat

Ankle Swelling

STOMACH/BOWEL

Black/Bloody Stools

Nausea/Vomiting (frequent)

Frequent Heart Burn/Acid (GERD)

Abdominal Pain

Diarrhea (frequent)

Constipation

Difficulty Swallowing

Vomiting Blood

KIDNEY/BLADDER

Urinary Incontinence

Urinary Hesitancy

Frequent Urination

Urinary Urgency

Painful Urination/Dysuria

REPRODUCTION

Inability to Have an Erection

Painful Intercourse

Decreased Sexual Desire

Sexually Transmitted Diseases

WOMEN

Breast Pain/Lumps

Frequent Sweats/Hot Flashes

Menopause

Menstrual Problems

Pelvic Pain

Pregnancy Problems

Vaginal Discharge

SKELETAL

Back Pain (major)

Neck pain (major)

Joints Swelling/Stiffness

Left Leg Pain

Right Leg Pain

NEURO

Numbness or Tingling

Severe Frequent Headaches

Forgetfulness/Confusion

Weakness

Headache

SKIN & HAIR PROBLEMS

Changes in Hair/Hair Loss

Persistent Rash

Changes in Moles

PSYCH/SOCIAL

Feeling Blue/Discouraged

High Anxiety/Stress