DIRECT ACCESS
INTERNAL MEDICINE

Date: _____

Patient Name: _____

Date of Birth: _____

Last 4 of SSN: _____

Mailing Address: _____

Email: _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Alternate phone: _____

Emergency Contact: _____

Marital Status: _____ **Current or Former Occupation:** _____

Current Health Issues (Diagnoses). e.g. Diabetes, Hypertension:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Surgical History and Hospitalizations:

_____

_____

_____

_____

_____

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

Current Medications, including any over the counter medications:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Vitamins/Supplements you are currently taking:

_____

_____

_____

_____

_____

Medication Allergies and Reaction:

_____

_____

_____

_____

_____

Other Allergies:

_____

_____

_____

Nicotine use : Y ___ N ___ Current _____ Former _____ How long and how many packs per day: _____

Alcohol use: Y ___ N ___ Current _____ Former _____ How many drinks per day: _____

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

Family Medical History (Significant health problems and who was affected, Parent, Sibling, Children, etc):

_____

_____

_____

_____

_____

Preventative Health History:

Colonoscopy: Y _____ N_____

Mammogram: Y _____ N _____

PSA: Y _____ N _____

Pap Smear: Y _____ N_____

Bone Density: Y_____ N_____

Vaccinations:

Covid 19: Y _____ N _____

Influenza: Y _____ N _____

Pneumonia (PVX 23/Prevnar 13): Y _____ N _____

Shingles : Y _____ N _____

Tetanus: Y _____ N _____

Other:

_____

_____

_____

_____

Please add any additional information you would like to share here or attach additional sheets:

_____

_____

_____

PATIENT SIGNATURE: _____