continuum INTERNAL MEDICINE
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Established Patient Form

Todays's Date:_____

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

Has there been any changes since your last office visit?

- Medications ☐ Yes ☐ No
  If yes, please list_____
- Medical Diagnosis ☐ Yes ☐ No
  If yes, please list_____
- Allergies ☐ Yes ☐ No
  If yes, please list_____
- Surgeries or hospitalizations ☐ Yes ☐ No
  If yes, please list_____
- Family history ☐ Yes ☐ No
  If yes, please list_____
- Immunizations ☐ Yes ☐ No
  If yes, please list_____

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 ☐ Swollen glands

Endocrine .....
☐ Cold intolerance ☐ Excessive thirst ☐ Heat intolerance ☐ Weight loss

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 ☐ Vomiting

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

Musculoskeletal .....
☐ Back/Neck problems ☐ Painful joints ☐ Weakness

Skin .....
☐ Dry skin ☐ Itching ☐ Rash

Neurologic .....
☐ Dizziness ☐ Headache ☐ Memory loss ☐ Tingling/ Numbness

Psychological .....
☐ Anxiety ☐ Depressed mood