At Appalachian Regional Internal Medicine Specialists

Patient Name________________________________
Date of Birth________________________________
Phone Number________________________________
Please Fill in or Affix a Patient Label

Patient Information (Adult)

Date: __________________ ☐ **Male** ☐ **Female** **Date of Birth:** ____/____/_____

Name: First________________________ Middle________________________ Last________________________

Address: ________________________________ **City/State/Zip:** ________________________

Home Phone: ________________________________ **Work Phone:** ________________________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Education Level: ________________________________ **Occupation:** ________________________

Employer: ________________________________

Reason for Today's Visit:

Medical History

Medications:

1. Non-Prescription - ☑ any taken regularly

☐ Vitamins ☐ Aspirin
☐ Laxatives ☐ Antacids
☐ Decongestants ☐ Tylenol
☐ Other: ________________________________

2. Prescription – (including Birth Control Pills)

Medication	Dosage	# Times/Day

Immunizations: (☑ Any Recived)

☐ Measles ☐ German Measles
☐ Mumps ☐ Smallpox
☐ Hemophilus ☐ Pneumonia
☐ Hepatitis ☐ Influenza
☐ TB Skin Test: _______________ Pos:______ Neg: ______

☐ Tetanus Series (Dates): ________________________________

Allergies: (☑ Any You Are Allergic To)

☐ Animals ☐ Demerol ☐ Penicillin
☐ Aspirin ☐ Grasses ☐ Pollens
☐ Codeine ☐ Insect Bites ☐ Sulfa

Based on answer above:
Which Antibiotics? ________________________________
Which Foods? ________________________________
☐ Other: ________________________________
What reaction? ________________________________
☐ No Known Allergies

Habits:

Do you use tobacco? ☐ Yes ☐ No
☐ Chew ☐ Smoke

If yes, what kind? ________________________________
If yes. How much? ________________________________

Do you drink alcohol?	☐ Yes	☐ No
Do you use drugs?	☐ Yes	☐ No
Do you drink caffeinated beverages?	☐ Yes	☐ No
Do you wear your seat belt?	☐ Yes	☐ No
Do you wear a helmet when biking?	☐ Yes	☐ No
Do you wear sunscreen/sunglasses?	☐ Yes	☐ No
Do you sleep well?	☐ Yes	☐ No
Do you eat well?	☐ Yes	☐ No
Do you exercise regularly?	☐ Yes	☐ No
Do you examine breasts/ testes monthly?	☐ Yes	☐ No
Have you used Narcotics or additive drugs?	☐ Yes	☐ No

Types: ________________________________

In your home do you have:
Smoke detectors? ☐ Yes ☐ No
Carbon monoxide detectors? ☐ Yes ☐ No

Have you been exposed to chemicals, toxins, poisons, fumes, smoke or radioactive materials at home or work?
☐ Yes ☐ No How often? ________________________
Types: ________________________________

Have you experienced any of the following?

☐ Marriage difficulties ☐ Job difficulties
☐ Sexual difficulties ☐ Sexual attack
☐ Nervous breakdown ☐ Sleep difficulties
☐ Emotional problems ☐ Depressions

How many people live in your Home? ____________________

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