advocare | Lawrenceville Internal Medicine

Name_____ Age_____ Date of Birth _____
How did you hear about us? _____
Reason for visit _____ Date of visit _____
Additional concerns or questions you would like to address _____
_____

Condition	Yes	No	Date Diagnosed
High Blood Pressure			
High Cholesterol			
Heart Disease			
Diabetes			
Blood Clot			
Stroke			
TIA (mini-stroke)			
Seizure			
Migraine			
Depression			
Anxiety			
Asthma			
Emphysema/COPD			
Positive PPD			
Tuberculosis			

Condition	Yes	No	Date Diagnosed
Reflux Disease			
Diverticulitis			
Hemorrhoids			
Colon Polyps			
Kidney Stones			
Osteoporosis			
Thyroid Disease			
Anemia			
Bleeding Disorder			
Joint Disease			
Skin Condition			
Eye Disease			
Hearing Loss			
Cancer			
Other Conditions			

Please list all prescription and over the counter medications/supplements you are taking

Medication	Dosage	How Often	Date Started

Please list any allergies

Drug	
Food	
Environmental	

Please List Previous Surgeries or Hospitalization

Reason for Surgery or Hospitalization	Date of Surgery or Hospitalization

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Name _____ Date of Birth _____

Please describe the following habits

Tobacco	○ Never	◉ Previously	○ Rarely	○ Occasionally	○ Daily
Alcohol	○ Never	○ Previously	○ Rarely	○ Occasionally	○ Daily
Recreational Drugs	○ Never	○ Previously	○ Rarely	○ Occasionally	○ Daily
Vaping	○ Never	○ Previously	○ Rarely	○ Occasionally	○ Daily
Caffeine	○ None	○ 1-2 cup daily	○ 3-4 cups daily	○ More than 4 cups daily	
Exercise	○ None	○ 1-2 times weekly	○ 3-4 times weekly	○ More than 4 times weekly	

Please list any medical conditions in your family

Family Member	Living	Deceased	Age	Diseases
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Gradnfather				
Brother				
Sister				

Please indicate if you have received the following tests

Test	Yes	No	Date/Results	Test	Yes	No	Date/Results
Cholesterol				Colonoscopy			
Blood Sugar				Mammogram			
Blood Pressure				Pap Smear			
EKG				Prostate Test			
Stress Test				Other			

Please indicate if you have received the following vaccines

Vaccine	Yes	No	Date	Vaccine	Yes	No	Date
Tdap(Tetanus)				Prevnar			
Pneumovax				Shingrix			
Influenza				Zostavax			
Other				Other			

For female patients

Problems with fertility _____

Age of 1st period_____ Age of menopause _____

Irreg menses? _____ Date of last menses_____

Bleeding between periods? _____

Number of Pregnancies ____ Complications _____

Number of children _____

For male patients

Problems with fertility _____

Number of children _____