Georgia Internal Medicine Partners, LLC

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DIPLOMATE
American Board of Internal Medicine

Nurse Intake Sheet

Name: ____
Last First MI

Home # ________________ Cell # __________________ Work # ______________________

DOB ____________ Age: __________ SSN: _________________

Occupation: ____________________ Marital Status: ________ Live Alone? ________

Who referred you to us? _________________________

What is your main complaint or symptom at this time? _________________________________

How long has this been a problem? ____

Please check the symptoms that you currently have related to this problem:

○ Fever: How high/how long present? ____

○ Tiredness : Describe ____

○ Weight loss: How much, what period of time? ____________________________________

○ Headaches: Describe ____

○ Blood in stool, Black stool: Describe ____

○ Vision Problems: Describe ____

○ Shortness of Breath: When and unusual aspects? _________________________________

○ Chest Pain: Describe ____

○ Palpitations: Describe ____

○ Nausea & vomiting: Describe ____

○ Diarrhea: How often? ____

○ Depression: How long? ____

○ Sleep problems: How long and describe ____

○ Swelling in legs: Any association with breathing problems? __________________________

○ Problems with urination: Pain or difficulty? _____________________________________

Females Only:

○ Menstrual problems — Pregnancies- Number ____

○ Pregnant — Children- Number ____

Check if applicable:

○ Blood transfusion ○ High risk of AIDS infection

Doctor's previously seen and the reasons for seeing them: ______________________________

____

Operations and surgeries with dates: ____

____

Medical Problems (e.g. thyroid, diabetes, heart disease, etc.): ____________________________

____

Current Medications: ____

____

Medication Allergies: ____

Family History

Mother: ____

Father: ____

Any other relevant family history? ____

____

Do you smoke? ____ If yes, how many years, and how many per day? ___________________

If relevant, what year did you quit? ____

Alcohol (social, never, on occasion, every day, etc.): ____________________________________

Any other helpful information that may be useful to the doctor? __________________________

____

Pharmacy you want medications called/sent to:____

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Weight __________ Height __________ BP__________ P__________