INTERNIST ASSOCIATES OF CENTRAL NEW YORK, PC
739 Irving Avenue Suite 200, Syracuse NY 13210
315-479-5070/Toll Free 1-800-890-5070

PRE-EXAMINATION INFORMATION

Name: ____ Date of Birth: __________ Age: ____
First M. Last

Address: ____ Phone #: ______________

Do you have any complaints today regarding your health? ______________________________

____

Current Occupation: ______________________________ Marital Status: ______________

Do you have a: Health Care Proxy? __________ Living Will? __________ DNR? __________

List Other Doctors you see: ____

PAST HISTORY

Since your last visit have you had any change in family or personal history? ______________

______________________________ Any family history of: Cancer ☐ Cardiovascular Disease ☐

Have you been hospitalized or had any surgery since your last visit? ______________________

Reason	Year	Hospital	Physician

Have you had any procedures done (ex: x-ray, CT Scan)? ______________________________

Have you had any serious injuries? ____

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Have you had any immunizations? ____

Please list present medications with dosage and how taken (Bring all medicines to your appointment):

1) ______________ 2) ______________ 3) ______________

4) ______________ 5) ______________ 6) ______________

7) ______________ 8) ______________ 9) ______________

Do you use non-prescription medicines, diet supplements, vitamins, calcium, iron, etc? ______________

____

Do you have any allergies to medications? ____

SINCE YOUR LAST EXAM, have you had any problems with?

Review of Systems	Yes	No	Comment/Explanation
Head			
Eyes			
Ears, Nose, Throat			
Heart, Chest Pain, Palpitations, Hypertension			
Respiratory – Cough, Trouble Breathing			
Breast			
Heartburn, Belching, Nausea, Bloating			
Change in Bowel Habits, Abdominal Pain			
Urinary Problems, Kidney Stones, Liver Disease			
Sexual Difficulties			
Musculoskeletal (Arthritis), Back Pain			
Endocrine (Diabetes or Thyroid Disorder)			
Anemia or problems with Lymph Nodes			
Neurological – Tingling, Loss of sensation			
Depression, Anxiety, Memory Loss			
Skin			
Change in Energy Level			
Change in Sleep Habits, Anxiety, Depression			
Allergies			
Do you: Smoke?			
Do you: Drink Alcohol?			
Do you: Use other Drugs?			
Do you: Drink Caffeine?			
Do you: Exercise?			

FOR WOMEN ONLY:

Name of OB/GYN Physician: ____________________

Date of last Pap Smear: ____________________

Date of last Mammography: ____________________

Date of last bone density: ____________________

Date of last breast examination: ____________________ Do you do self-exams? __________

Date of last Menstrual Cycle: ____________________ Age at Menopause: ____________________

FOR MEN ONLY:

Date of last PSA: ____________________

FOR WOMEN AND MEN:

Date of last Colonoscopy/Sigmoidoscopy: ____________________

______________________________ ______________________________

Patient Signature Date Reviewed By Date