# INTERNAL MEDICINE SPECIALIST OF LAS VEGAS

Today's Date:_____

NAME:_____ SSN:_____

OCCUPATION:_____ EMPLOYER:_____

DATE OF BIRTH:_____ AGE:_____ MALE OR FEMALE

**ALLERGIES:** Please list type of allergy and reaction

| Name of Drug or Type of Allergy | Reaction |
|---|---|
| | |
| | |
| | |
| | |

**CURRENT MEDICATION:** Please list all medication you take and their dosages

| Medication | Dosage | Medication | Dosage |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**PREVIOUS HOSPITALIZATIONS/SURGERIES:**

| Year | Hospital/City | Reason | Physician |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**PAST MEDICAL HISTORY:** Please indicate whether you have ever had:

| | | Condition | | | Condition |
|---|---|---|---|---|---|
| Y | N | High Blood Pressure | Y | N | Asthma |
| Y | N | Heart Attack | Y | N | Kidney Stones |
| Y | N | Diabetes | Y | N | Kidney Disease |
| Y | N | Stomach Ulcers | Y | N | Pneumonia |
| Y | N | Gout | Y | N | Arthritis |
| Y | N | Liver Disease/Hepatitis | Y | N | Gallbladder Disease |
| Y | N | Thyroid Disease | Y | N | Anemia |
| Y | N | Psoriasis | Y | N | Increased Cholesterol |
| Y | N | Cancer | Y | N | Blood Transfusion |
| Y | N | Stroke | Y | N | Histroy Of Heart Murmur |

Y N Accident/Broken Bones (please list):_____

Other Medical Condition/Problems not _____

_____

FEMALES ONLY: Are you or could you possibly be Pregnant? Y N Date of last menstrual period_____