PENEPENT, MD
INTERNAL MEDICINE

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BOWMANSVILLE, NY 14026
PHONE (716) 681-1895 / FAX (716) 681-5439

Please complete this entire packet and mail back or bring with you to your scheduled appointment.

Name_____DOB_____Date_____

Please list the full name & contact number of all physicians/specialists whom you are currently under the care of:

Physician/Specialist Name	Contact Number	Reason

Previous physician or referring physician: _____

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

With whom do you currently live? _____

Are you currently working? Yes □ No □ What is your occupation: _____

Hand dominance: Right-handed □ Left-handed □ ambidextrous □

Please check if you are: Blind □ Deaf □ Hard of Hearing □

Please check if you use the following: Glasses □ Contacts □ Dentures □ Hearing Aid □ Walker □
Cane □ Wheelchair □ Brace □

or the following questions if you need more room please use the space in the box on page 3:

Please list any surgeries you have had and the date:

Type	Date	Doctor

Have you ever had any complications with anesthesia? If yes, please describe:_____
_____

Please list your diagnosis (medical conditions) both mental and physical given to you by a medical professional:

Diagnosis	Doctor

List your current medical problems, including any substance addiction or abuse:

Recreational Drugs: _____

Date of last: Tetanus Shot: _____ Flu Shot_____ Pneumonia Shot_____ PPD_____ Shingles_____
(Please bring shot records or have them faxed to our office prior to your visit).

Date of last eye exam: _____

Date of last dental exam: _____

If over 50 have you had a colonoscopy? Y / N Date & Doctor _____

Women: Date of last Pap Smear_____ Mammogram_____
Bone Density Scan _____ Name of your OB/GYN:_____

Family History

	Living or Deceased	Please list any health problems, diagnosis, mental problems or substance abuse for each.
Mother		
Father		
Brothers1		
Brother 2		
Brother 3		
Sister 1		
Sister 2		
Sister 3		

On average, how many hours of sleep do you get per night? _____ Do you have trouble sleeping? Please explain: _____

Do you smoke? _____If so, how many per day? _____Did you ever smoke? _____ If so, how long_____

When did you quit? _____Never smoked_____

Do you drink alcohol? _____If so, how many per week? _____

Do you consume caffeine? _____Please specify type _____How many per day? _____

How often do you exercise? Never □ Rarely □ Sporadic □ Regularly □

Do you have any tattoos? _____ Please list locations: _____

Do you have any piercings? _____ Please list locations: _____

What is your sun exposure? Minimum □ Moderate □ Excessive □ Do you wear sunscreen? _____SPF_____

Do you wear a seatbelt in the car? _____

Please check if you are currently experiencing any of the following:

☐ Skin rashes, changes in any moles or skin lesions

☐ Headaches, dizziness, fainting

☐ Eye problems/discomfort, double or blurred vision

☐ Bloody nose, nasal discharge

☐ Neck pain, stiffness, swelling, limitation in motion

☐ Chest cold, clearing throat, dry cough, coughing up blood, chills, fever, night sweats

☐ Shortness of breath, rapid or irregular heartbeat, ankle/leg swelling, wheezing

☐ Open sores on feet/legs, pain/discomfort in the legs, chronic cold feet, blue discoloration of feet/toes

☐ Increased appetite/loss of appetite, difficulty swallowing, vomiting blood, unusual belching or gas from rectum, change in bowel habits or color, weight loss, heartburn

☐ Yellow skin/eyes, constipation, diarrhea, pain with bowel movements, rectal bleeding, hemorrhoids, increased urination, painful urination, blood in urine, nighttime urination, hesitancy, dribbling

☐ Abnormal periods, heavy bleeding, painful cramping, spotting between periods, vaginal discharge

☐ Easy bruising, swollen or enlarged lymph nodes, anemia

☐ Unusual increase in urination, weight gain/loss, unusual sweating, chronic fatigue, hair loss, increased thirst, severe dry skin

☐ Joint pain, joint swelling, muscle pain, muscle swelling, joint/muscle stiffness/cramping

☐ Confusion, decreased memory, unable to concentrate, difficulty speaking, difficulty walking, loss of bladder control or bowels, numbness or tingling in arms/legs

USE THIS SPACE FOR ANY QUESTIONS IN WHICH EXTRA SPACE IS NEEDED

NEXT PAGE
PERSONAL MEDICATION LIST

*** PLEASE BRING ALL OF YOUR MEDICATION BOTTLES WITH YOU TO YOUR APPOINMEMNT.**

Prescription Medications	Purpose or Reason Taken	Dose	Time(s) of Day	Form (Liquid, capsule, tablet)	Special Instructions
Over-the-Counter Medications/Vitamins	**Purpose or Reason Taken**	**Dose**	**Time(s) of Day**	**Form (Liquid, capsule, tablet)**	**Special Instructions**

Local Pharmacy_____ **Pharmacy Phone** _____

Drug Allergies: _____

_____

_____

**** PLEASE BRING THE FOLLOWING ADVANCED DIRECTIVES IF YOU HAVE THEM: HEALTH CARE PROXY, DO NOT RESUSCITATE ORDER, DO NOT INTUBATE ORDER, LIVING WILL**