# INTERNAL MEDICINE ASSOCIATES

## YOUR HEALTH REVIEW

Place an (*) beside any question you do not understand.

**CURRENT INFORMATION** **TODAY'S DATE:** ____ / ____ / ____

Your Name: _____ Date of Birth: _____

Name you prefer to be called: _____ Age: _____

Street Address: _____

City: _____ State: _____ Zip code: _____

**Telephone Numbers:** Daytime ( ____) _____ Evening: (____ ) _____

❒ Male ❒ Female Social Security # ____ - ____ - ____ Last Grade Finished: _____

❒ Single ❒ Married when? _____ ❒ Divorced when? _____ Widowed when? _____

Occupation: _____ Retired when? _____

Hobbies/Interests: _____

Religious Denomination (optional): _____

**Person to contact in an Emergency:** Name _____

Relationship to you _____ Phone # _____

**Pharmacy** you normally use _____ Phone # _____

**Previous physicians** you have seen _____

Last exam date ____ / ____ / ____ Physician _____

Were you referred to our clinic? _____ If so, by whom? _____

**Insurance Plan** _____ Policy Number _____

Policy Holder _____ Group Number _____

**Policy Holder D.O.B.** _____

**Second Insurance Plan** _____ Policy Number _____

Policy Holder _____ Group Number _____

**Policy Holder D.O.B.** _____

**REASON FOR YOUR VISIT TODAY**

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