KERNODLE CLINC – INTERNAL MEDICINE

1234 Huffman Mill Rd., Burlington, NC 27215 336-538-2360

Name:_____ Date of Birth: ___/___/___ Age: ____ Sex: _____

Address: _____
Street City State Zip Code

Telephone: _____ (Home) _____ (Cell) _____ (Work)

Emergency Contact: _____
Name Relation Phone Number

☐ I Decline an Emergency Contact

Do you have a living will? ☐ Yes ☐ No (If yes, do we have a copy on file? __)

Are you and Organ Donor? ____

Please briefly state in the box below the reason for your visit
Reason for Visit:
Personal Physician:
Referred by:

Past Medical History

Condition / Disease	Year Began	Condition / Disease	Year Began
☐ Hypertension		☐ Cancer- Type	
☐ High Cholesterol		☐ Migraines	
☐ Hypo/Hyperthyroidism		☐ Anemia	
☐ COPD, Emphysema or Asthma		☐ Kidney Stones	
☐ Diabetes		☐ Ulcers/Stomach Issues	
☐ GERD		☐ Epilepsy / Seizures	
☐ Depression or Anxiety			
☐ Heart Problems			

Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures

Operation/ Hospitalization/ Injury	Month / Yr	Operation/ Hospitalization/ Injury	Month / Yr

Drug or Food Allergies

List below medications or foods causing an allergic reaction (i.e. rash, swelling) or intolerance (i.e. nausea)

Medication / Food	Reaction	Medication / Food	Reaction

Medications, Vitamins and Herbal Supplements

Medication	Strength	Number of Pills Taken & Frequency	Medication	Strength	Number of Pills Taken & Frequency
Example: Tylenol	*500mg*	*1 – Twice Daily*			

Social, Educational, and Work History

Marital Status:	Number of Children: Age(s):	
Work Status (circle one): Employed / Unemployed / Retired / Disabled	Current or Prior Occupation:	Hours Worked Per Week:

Do you drink alcohol? □ Yes □ No	What type of alcohol?	No. of Drinks per Week?
Are you a current smoker? □ Yes □ No	If you smoke, how many packs per day?	
Are you a former smoker? □ Yes □ No	On average, how much did you smoke per day?	
Do you have caffeine? □ Yes□ No	How much per day?	

Family Health History

Please list below the health history of your blood (genetic) first degree relatives.

Relative	Living or Deceased	Current Age or Age at Death	Cause of Death	Health Problems
Father:				
Mother:				
Brother(s):				
Sister(s):				

Were you adopted? □ Yes □ No

Disease Prevention and Health Maintenance

Please list below the most recent dates of your vaccines and health screening tests.

	Month/ Yr		Month/Yr		Month/ Yr
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine		Pap Smear		Heart Cath	
Tetanus Vaccine		Colonoscopy		Endoscopy	
Hepatitis B Vaccine		Bone Density		Heart Stress Test	
Shingles Vaccine		EKG		Ab Aneurysm Screen	
Gardasil Vaccine		Chest XRay		HIV Test	

Review of Symptoms

Please review the following symptoms and check those that are a problem for you

□ Vision Problems	□ Chest Pain	□ Trouble Swallowing	□ Weakness
□ Hearing Problems	□ Chest Discomfort	□ Nausea	□ Fatigue
□ Hay Fever	□ Shortness of Breath	□ Vomiting	□ Fever / Sweating
□ Nosebleeds	□ High Blood Pressure	□ Diarrhea	□ Fainting
□ Sore Throat	□ Diabetes	□ Abdominal Pain	□ Seizures / Tremor

□ Hoarseness	□ High Cholesterol	□ Hepatitis / Jaundice	□ Headaches
□ Lumps in Neck	□ Lumps In Breast	□ Gallstones	□ Numbness / Tingling
□ Tooth Problems	□ Breast Discharge	□ Constipation	□ Anxiety / Depression
□ Cough	□ Frequent Urination	□ Blood in Stool	□ Difficulty Sleeping
□ Coughing Blood	□ Incontinence	□ Pain In Legs	□ History of STD's
□ Wheezing	□ Blood in Urine	□ Joint Pain / Stiffness	□ TB Exposure
□ Asthma / COPD	□ Anemia	□ Weight Loss / Gain	□ Excessive Hunger
□ Emphysema	□ Easy Bruising	□ Heat Intolerance	□ Excessive Thirst
□ Bronchitis	□ Blood Clot	□ Cold Intolerance	□ None Listed

Please list any other pertinent information to your care that you would like your provider to know.

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Thank you for choosing Kernodle Clinic Internal Medicine as your Primary Care Provider!