



**HUNTSVILLE INTERNAL MEDICINE ASSOCIATES**  
250 CHATEAU DRIVE, SUITE 220  
HUNTSVILLE, ALABAMA 35801  
(256) 881-1989

PREPARE FOR DR. KEVIN FRENCH

**NEW PATIENT INFORMATION**

Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_

DOB: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status: Married \_\_\_\_\_ Single \_\_\_\_\_ Number of Children: \_\_\_\_\_

Reason for Today's Visit: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List Any Chronic Medical Problems: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List Any Previous Surgeries: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List Medications:		
Name:	Dose:	Directions:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List Allergies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please Check Any Of The Following Diseases That Occur In Your Family:

Stroke \_\_\_\_ Heart Attack \_\_\_\_ Cancer \_\_\_\_ Diabetes \_\_\_\_ Heart Failure \_\_\_\_ Arthritis \_\_\_\_

High Blood Pressure \_\_\_\_ Tuberculosis \_\_\_\_ Mental Illness \_\_\_\_ Lung Disease \_\_\_\_

Kidney Disease \_\_\_\_ Anemia \_\_\_\_

Other (Please List): \_\_\_\_\_

\_\_\_\_\_

Please Check Any Of The Following Symptoms That You May Have:

Headache \_\_\_\_ Numbness \_\_\_\_ Weakness \_\_\_\_ Poor Vision \_\_\_\_ Poor Hearing \_\_\_\_

Chest Pain \_\_\_\_ Abdominal Pain \_\_\_\_ Diarrhea \_\_\_\_ Constipation \_\_\_\_ Palpitations \_\_\_\_

Swelling \_\_\_\_ Joint Pain \_\_\_\_ Weight Loss \_\_\_\_ Weight Gain \_\_\_\_ Nervousness \_\_\_\_

Depression \_\_\_\_ Sinus Congestion \_\_\_\_ Cough \_\_\_\_ Rash \_\_\_\_

Other (Please List): \_\_\_\_\_

\_\_\_\_\_

Do You Smoke? \_\_\_\_\_ If Yes. How Long \_\_\_\_\_

Do You Drink Alcohol? \_\_\_\_\_ If Yes. How Many Drinks/Week \_\_\_\_\_

When Was Your Last Tetanus Shot? \_\_\_\_\_

Have You Had a Pneumonia Vaccine? \_\_\_\_\_

Have You Had A Flu Vaccine? \_\_\_\_\_

Have you had a colonoscopy? \_\_\_\_\_

Is there a Family history of colon cancer? \_\_\_\_\_

FOR WOMEN: Last Pap Smear? \_\_\_\_\_ Last Mammogram? \_\_\_\_\_

FOR MEN: Last Prostate Exam? \_\_\_\_\_ PSA Levels? \_\_\_\_\_