Welcome to the Internal Medicine Associates!

Who we are
We are a primary care clinic at Mount Sinai Hospital. We are a team of doctors, nurses, medical assistants, and social workers all working together to provide you with the best care possible.

Services we provide
- Check-ups
- Management of medical problems
- Referrals to specialty clinics, if needed
- Mental health, diabetes, joint problems, and hepatitis C clinics
- Nutrition counseling and much more!

How the clinic runs
At your first visit, a doctor will be assigned to you as your primary care doctor. All doctors are supervised by a group of senior doctors.
*** The name of the doctor on your insurance card will be of one of the senior doctors, and may be different than who is your primary care doctor in the clinic.

What to expect on your first 1-2 visits
- Questions about illnesses and any other concerns
- Tests/injections depending on your age
- Check up
*** We may not have time to cover everything at the first visit, but we will make a follow-up appointment in a few weeks so that we can discuss all your concerns.

At each clinic visit, you will:
1. have your blood pressure, heart rate, temperature checked
2. meet with the doctor, who will at the end of visit, step out to go over the plan with the senior physician
3. do blood work/injections, if needed
4. make a follow up appointment at the front desk
*** Please note, we try our best to schedule you with your own doctor for each visit, but due to doctor’s schedules, you may sometimes see another member of the team.
IMA NEW PATIENT QUESTIONNAIRE
PLEASE GIVE THIS FORM TO YOUR DOCTOR AT YOUR VISIT TODAY

TODAY'S VISIT:

What are the two most important things you would like to talk about with your doctor today?

1. ____________________________________________
2. ____________________________________________

Do you need forms filled out or a letter?  YES   NO

PAST MEDICAL HISTORY:
Please list your medical problems.
Use other side if needed.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Allergies: _________________________________________________________________

Have you been hospitalized in the past year?  YES   NO
If yes, for what and where? ___________________________________________________

PAST SURGICAL HISTORY:
Please list any surgeries or procedures you have had done. Include dates, if known.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

FAMILY HISTORY:
List any problems that run in the family (such as diabetes, cancers, heart disease):

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

PRIOR MEDICAL CARE:
Where have your previous doctors been?

________________________________________________________________________

To help us take better care of you, please bring any other medical records you have to your next visit.
If you have time, please answer the following questions:

**GENERAL HEALTH SCREENING:**

- Do you currently smoke? YES  NO
  - If yes, would you like to quit? YES  NO

Over the past two weeks, have you been bothered by any of the following problems?

- Little interest or pleasure in doing things: YES  NO
- Feeling down, depressed, or hopeless: YES  NO

Are you receiving counseling or mental health services elsewhere? YES  NO
  - If yes, for what and where?

Have you fallen in the past year? YES  NO
In the past year, have you been afraid that you might fall? YES  NO

Do you want a flu vaccine today? YES  NO
Would you like to be tested for HIV? YES  NO
If born 1945-1965: would you like to be tested for Hepatitis C? YES  NO