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.

_____
_____
_____
_____
_____
_____
_____
_____
_____

MEDICATIONS:

Please list any medications you are taking.
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