



Metro Internal Medicine P.A.
Facsimile Transmittal Sheet
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MEDICAL/FAMILY/SOCIAL HISTORY

Date: _____

Patient Name: _____ Date of Birth: _____

Social Security # _____

PAST MEDICAL/SURGICAL HISTORY (PLEASE INCLUDE DATES):

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

MEDICATION (INCLUDE DOSAGE):

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES: _____

SOCIAL HISTORY:

Smoker (INCLUDE # OF PACKS/FREQUENCY): _____

Alcohol (INCLUDE FREQUENCY): _____

Occupation: _____

Exercise (Cardio/Weights, Frequency): _____

FAMILY MEDICAL HISTORY:

Cancer (INCLUDE TYPE): _____

Heart Disease: _____

Diabetes: _____

Other Medical Conditions: _____

Patient Signature: _____ Date: _____

I authorize the release of any medical or other information necessary to process claims on my behalf. I agree to be fully responsible for all lawful debts incurred by myself for services received from Metro Internal Medicine whether covered by insurance or not.