

PATIENT INTAKE FORM

Date: _____

INSTRUCTIONS: Please fill out as completely as possible.

1. Patient Name: _____
Last
First
MI

2. Date of Birth: _____ Place of Birth: _____

3. Marital status: _____
 Number of children: _____ Ages of children: _____

4. Occupation: _____

5. Employer: _____

6. Referring Physician: _____ Phone: _____
 Address: _____

7. Reason(s) for this visit: _____

8. Travel History (List places you have lived or traveled that might be associated with today's visit): _____

9. Have you had contact with pets or animals (explain): _____

10. Past medical problems:

	Date	Problem

11. Hospitalizations and surgeries:

	Date	Reason or surgery

12. **PRESENT MEDICATIONS:** (Bring with you to your appointment)

DRUGS	DOSE	TIMES/DAY

13. **DRUG ALLERGIES:** (List all known drug allergies)

14. **FAMILY HISTORY:**

	Age	<u>If Living</u> Health	Age	<u>If Deceased</u> Cause
Father				
Mother				
Brothers/Sisters				

15. Identify family members with any of the following:

- | | |
|--|--|
| <input type="checkbox"/> Alcoholism _____ | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> High Cholesterol _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Obesity _____ |
| <input type="checkbox"/> Depression _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Tuberculosis _____ |

16. **SOCIAL HISTORY**

Tobacco use:

If yes, _____ (number) of packs a day for _____ (number) of years

If quit, _____ (date) quit

Other types of tobacco:

Alcohol use:

If yes, number of ounces/week: _____

Sexual activity:

Sexual partner:

Method of birth control (if sexually active): _____

Pregnancy history: Number of pregnancies: _____ Never been pregnant

Drug use: If yes, type(s): _____

Use intravenous drugs Number of uses per week: _____

17. **STRESS PROFILE**

- | | |
|-----------------------------------|------------------------------------|
| I feel sad or unhappy | Other people do not interest me |
| I worry about the future | I can't make decisions |
| I feel I have failed | I look old and unattractive |
| I feel dissatisfied and bored | I can't work any more |
| I feel guilty | I have trouble sleeping |
| I feel I'm being punished | I feel tired all the time |
| I'm disappointed with myself | My appetite is poor |
| I blame myself for what happens | I have lost weight |
| It would be better if I were dead | I am worried about my health |
| I often cry | I am less interested in sex |
| I am irritable or angry | I would like to change my behavior |

18. **REVIEW OF SYSTEMS:** (Check if applicable)

GENERAL

- Change in weight
- Chills
- Fatigue
- Fever
- Trouble sleeping

ALLERGIES

- Food
- Pollens
- Other _____

BLOOD

- Anemia
- Bleeding disorder
- Enlarged lymph node
- Low white count

ENDOCRINE

- Cold intolerance
- Diabetes
- Excessive thirst
- Goiter
- Heat intolerance
- Increased perspiration
- Night sweats
- Radiation exposure
- Thyroid disease

HEART

- Blood clots of legs
- Chest pain
- Heart attack
- Heart murmurs
- High blood pressure
- Irregular beat
- Leg cramps
- Shortness of breath at night
- Swelling of ankles

HEAD AND NECK

- Headache
- Hearing problems
- Mouth sores
- Nose problems
- Sinus problems
- Visual problems

INFECTIOUS DISEASES

- Chicken pox
- Hepatitis
- Malaria
- Measles
- Mumps
- Parasites
- Traveler's diarrhea
- Tuberculosis

KIDNEYS AND BLADDER

- Blood in urine
- Discharge
- Frequent urination
- Leakage of urine
- Nighttime urination
- Pain on urination

LUNGS

- Cough
- Coughing up blood
- Pleurisy
- Pneumonia
- Shortness of breath
- Wheezing or asthma

MENSTRUAL HISTORY

- Irregular periods
- Pain
- Spotting

NEUROLOGIC

- Difficulty thinking
- Difficulty with memory
- Dizziness
- Incoordination
- Loss of consciousness
- Muscle wasting
- Panic attacks
- Paralysis
- Problem walking
- Vertigo
- Weakness or paralysis

SKELETAL

- Arthritis
- Bursitis
- Gout
- Muscle aches

SKIN AND HAIR

- Bruising
- Growths
- Loss of hair
- Rash

STOMACH AND BOWEL

- Abdominal pain
- Black stool
- Constipation
- Diarrhea
- Heart burn
- History of ulcer
- Jaundice
- Loss of appetite
- Problem swallowing
- Vomiting
- Vomiting blood