University Health Care
International Travel Clinic

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: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partnered
   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:**

	If Living		If Deceased	
	Age	Health	Age	Cause
Father				
Mother				
Brothers/Sisters				

15. Identify family members with any of the following:

☐ Alcoholism _____ ☐ High Blood Pressure _____
☐ Cancer _____ ☐ High Cholesterol _____
☐ Diabetes _____ ☐ Obesity _____
☐ Depression _____ ☐ Stroke _____
☐ Heart Disease _____ ☐ Tuberculosis _____

16. **SOCIAL HISTORY**

Tobacco use: ☐ Yes _____ number of packs a day _____ number of years
☐ No
☐ Quit Date quit: _____

Other types of tobacco:
☐ Pipe ☐ Snuff ☐ Cigar ☐ Chew

Alcohol use: ☐ Yes Number of ounces/week: _____
☐ No

Sexual activity: ☐ Yes Sexual partner: ☐ Male ☐ Female ☐ Both
☐ No
☐ Not currently

Method of birth control (if sexually active): _____

Pregnancy history: Number of pregnancies: _____ ☐ Never been pregnant

Drug use: ☐ Yes Type: _____
☐ No ☐ Use intravenous drugs Number of use per week: _____

17. **STRESS PROFILE**

	Yes	No	Sometimes
I feel sad or unhappy	☐	☐	☐
I worry about the future	☐	☐	☐
I feel I have failed	☐	☐	☐
I feel dissatisfied and bored	☐	☐	☐
I feel guilty	☐	☐	☐
I feel I'm being punished	☐	☐	☐
I'm disappointed with myself	☐	☐	☐
I blame myself for what happens	☐	☐	☐
It would be better if I were dead	☐	☐	☐
I often cry	☐	☐	☐
I am irritable or angry	☐	☐	☐
Other people do not interest me	☐	☐	☐
I can't make decisions	☐	☐	☐
I look old and unattractive	☐	☐	☐
I can't work any more	☐	☐	☐
I have trouble sleeping	☐	☐	☐
I feel tired all the time	☐	☐	☐
My appetite is poor	☐	☐	☐
I have lost weight	☐	☐	☐
I am worried about my health	☐	☐	☐
I am less interested in sex	☐	☐	☐
I would like to change my behavior	☐	☐	☐

28. **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