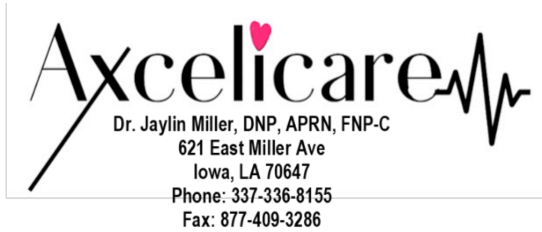
INTAKE FORM



DATE: ____

Patient NAME: ____ **PREFERRED NAME:** ______________________

DOB: ___________________________**ADDRESS:** ____

CITY/STATE/ZIP: ____

SSN: _______________________________ **E-MAIL:** ____

PHONE #: ____

EMERGENCY CONTACT NAME & NUMBER: ____

ADDITIONAL CONTACT NAME/NUMBER: ____

INSURANCE POLICYHOLDER/NAME OF INSURANCE COMPANY//POLICY #/:

____

____

Parent/Guardian Name (if patient is Minor): ____

Parent/Guardian Phone Number: ____

Parent/Guardian Address/City/State/ZIP: ____

Parent/Guardian Email Address: ____

DRIVER'S LICENSE NUMBER: ____

MARRIED: YES OR NO

SPOUSE NAME/NUMBER IF APPLICABLE: ____

WHAT BRINGS YOU IN TODAY/CHIEF COMPLAINT: ____

____

PHARMACY (MAY LIST MORE THAN 1) NAME/ADDRESS/CITY/PHONE NUMBER:

PRIMARY:____

SECONDARY:____

ALLERGIES WITH WHAT TYPE OF REACTION: ____

____

DO YOU HAVE A MEDICAL POWER OF ATTORNEY: YES OR NO

DO YOU HAVE A LIVING WILL: YES OR NO

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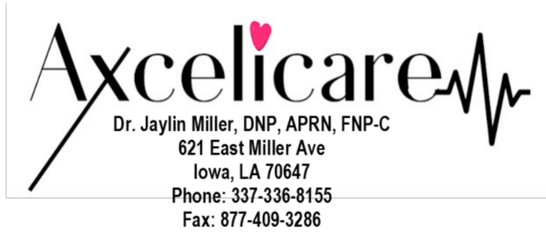
MEDICATION LIST INCLUDING PRESCRIPTIONS, VITAMINS, HERBAL SUPPLEMENTS, OTC MEDS:

MEDICATION NAME/DOSE	HOW DO YOU TAKE IT?	DAYS SUPPLY	REASON	NEED REFILL YES OR NO
EXAMPLE: LISINOPRIL 10MG	*1 TABLET ONCE A DAY*	*90*	*HIGH BLOOD PRESSURE*	*YES*



ANY OTHER MEDICAL HISTORY (WHAT HAVE YOU BEEN TREATED FOR OR DIAGNOSED WITH IN THE PAST):

____

____

____

SURGICAL HISTORY (HAVE YOU EVER HAD SURGERY?):

____

____

____

____

HOSPITALIZATION HISTORY (HAVE YOU EVER BEEN HOSPITALIZED?):

____

____

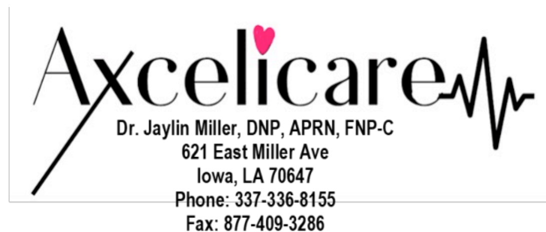
FAMILY HISTORY: PUT A CHECK IF APPLICABLE

RELATIVE	ALIVE (A) OR DECEASED (D)	HIGH BLOOD PRESSURE	HIGH CHOLESTEROL	TYPE 1 OR 2 DIABETES	HEART DISEASE	CANCER AND WHAT KIND?	OTHER
FATHER							
MOTHER							
PATERNAL GRANDFATHER							
PATERNAL GRANDMOTHER							
MATERNAL GRANDFATHER							
MATERNAL GRANDMOTHER							
SIBLING (S)							
CHILDREN							
OTHER							
NOTES							

HOW MANY OF EACH?

Siblings Brothers [ ] Sisters [ ] ☐ Healthy

Children Sons [ ] Daughters [ ] ☐ Healthy



LAST MENSTRUAL CYCLE: ____

SOCIAL HISTORY:

DO YOU SMOKE, VAPE, OR USE ANY OTHER NICOTINE PRODUCTS? ______________________________________

How many/much per day? ____

How many years have you used nicotine products? ____

Did you have a drink containing alcohol in the past year? YES or NO

If 'Yes' : How often did you have a drink containing alcohol in the past year?

Never (0 point)

Monthly or less (1 point)

2 to 4 times a month (2 points)

2 to 3 times a week (3 points)

4 or more times a week (4 points)

Declined to specify (0 points)

If 'Yes' : How many drinks did you have on a typical day when you were drinking in the past year?

1 or 2 drinks (0 point)

3 or 4 drinks (1 point)

5 or 6 drinks (2 points)

7 to 9 drinks (3 points)

10 or more drinks (4 points)

Declined to specify (0 points)

If 'Yes' : How often did you have 6 or more drinks on one occasion in the past year?

Never (0 point)

Less than monthly (1 point)

Monthly (2 points)

Weekly (3 points)

Daily or almost daily (4 points)

Declined to specify (0 points)

Have you used drugs other than those for medical reasons in the past 12 months? __________ If so, what is it and how often/much per day?

____

DO YOU DRINK CAFFEINE? YES or NO

How much per day?

none

1-2 cups per day

2-3 cups per day

3-4 cups per day

more than 4 cups per day

HEALTH MAINTENANCE – PLEASE LIST DATE LAST PERFORMED AND ABNORMAL OR NORMAL, IF APPLICABLE

MAMMOGRAM: ____

PAP SMEAR: ____

COLONOSCOPY: ____

COLOGUARD: ____

OCCULT STOOL TESTING: ____

BONE DENSITY SCAN: ____

AAA U/S SCREENING: ____

PSA TEST: ____

LUNG CANCER SCREENING: ____

EKG: ____

STRESS TEST: ____

ECHOCARDIOGRAM: ____

OTHER:

____

____

____

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REVIEW OF SYSTEMS

CIRCLE ANY SYMPTOMS YOU ARE HAVING:

GENERAL

Change in appetite
Chills
Fatigue
Fever
Headache
Lightheadedness
Night sweats
Sleep disturbance
Weight gain
Weight loss
Weakness

ALLERGY/IMMUNE

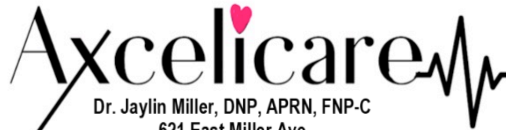
Blistering skin
Congestion
Cough
Hives
Itching
Rash
Recurrent serious infections
Seasonal allergies
Sneezing
Unusual reaction to medication(s), food, animals or insects
Watery eyes
Wheezing

EYES

Blurry vision
Change in vision
Diminished visual acuity
Discharge
Double vision
Dry eye(s)
Eye pain
Flashes of light in the visual field
Floaters in the visual field
Itching and redness of the eye(s
Itching and redness of the eyelid(s)
Loss of vision
Other eye problems
Pain
Red eye(s)
Tearing excessive
Vision screen
Watery eyes

EARS/NOSE/THROAT

Blocked ear(s)
Decreased hearing
Decreased sense of smell
Difficulty in swallowing
Dry mouth
Ear pain
Hoarseness
Nasal congestion
Nosebleed
Ringing in the ears
Scratchy throat
Sinus pain
Sinus problems
Sneezing
Sore throat
Swollen glands



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ENDOCRINE

Cold intolerance
Dizziness
Excessive sweating
Excessive thirst
Frequent urination
Hair loss
Heat intolerance
Hot flashes
Irregular menses
Weakness
Weight loss

RESPIRATORY

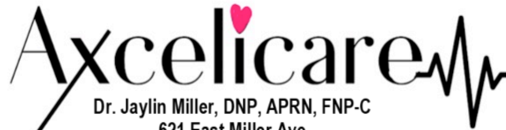
Chest pain
Chest tightness
Chronic cough
Cough
Bloody Sputum
Pain with inspiration
Shortness of breath
Shortness of breath at rest
Shortness of breath with exertion
Sputum production
Wheezing

BREAST

Bloody nipple discharge
Breast lump or mass
Breast pain
Breast swelling
Nipple discharge
Persistent breast pain
Red Skin

CARDIOLOGY

Chest pain
Chest pain at rest
Chest pain with exertion
Claudication
Congenital heart problems
Cyanosis
Difficulty laying flat
Dizziness
Dyspnea on exertion
Fluid accumulation in the legs
Heart murmur
High blood pressure
Irregular heartbeat
Orthopnea (difficulty breathing lying down)
Other vascular anomalies
Palpitations
Rheumatic fever
Shortness of breath
Swelling in hands / feet
Weakness
Weight gain



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GASTROENTEROLOGY

Abdominal pain
Blood in stool
Change in bowel habits
Colitis
Constipation
Decreased appetite
Diarrhea
Difficulty swallowing
Exposure to hepatitis
Heartburn
Hepatitis
Jaundice
Nausea
Rectal bleeding
Stomach problems
Vomiting
Weight loss

HEMATOLOGY

Anemia
Easy bleeding
Bleeding problems
Easy bruising
Fever
Groin mass
Prolonged bleeding
Recent transfusion
Swollen glands
Weakness
Weight loss

GYN

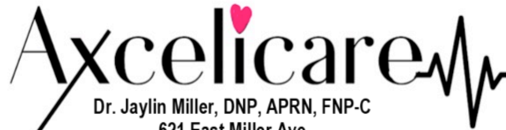
Abnormal bleeding
Breast lump
Breast pain
Discharge from the breast
Heavy bleeding during menses
Hot flashes
Irregular menses
Missed periods
Painful intercourse
Painful menses
Pelvic pain
Vaginal bleeding between periods
Vaginal discharge / itching

URINARY

Blood in the urine
Difficulty urinating
Frequent urination
Loss of urine with cough or laughter
Painful urination
Poor urine output

MUSCOLOSKELETAL

Arthritis / arthralgia
Back pain
Back problems
History of gout
Joint stiffness
Leg cramps
Limping gait
Muscle aches
Muscle spasms
Neck pain
Pain in shoulder(s)
Painful joints
Sciatica
Swollen joints
Trauma to arm(s)
Trauma to hip(s)
Trauma to knee(s)
Trauma to ankle(s)
Weakness



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PERIPHERAL VASCULAR

- Absent pulses in feet
- Absent pulses in hands
- Blanching of skin
- Blood clots in legs
- Cold extremities
- Decreased sensation in extremities
- Pain / cramping in legs after exertion
- Painful extremities
- Ulceration of Feet

PODIATRY

- Achilles pain
- Achilles swelling
- Ankle pain
- Ankle swelling
- Ball of foot pain
- Big toe pain
- Big toe swelling
- Burning of the feet
- Difficulty walking
- Foot numbness
- Foot pain
- Foot swelling
- Joint dislocation
- Redness over the achilles
- Sole pain
- Toe(s) problem
- Wound oozing

SKIN

- Acne
- Blistering of skin
- Changing moles
- Discoloration
- Dry skin
- Eczema
- Excessive sun exposure
- Hair changes
- Hives
- Itching
- Keloid formation
- Masses
- Mole(s)
- Nail changes
- Nodule(s)
- Photosensitivity
- Rash
- Rash on feet
- Scaly lesions of skin
- Skin cancer
- Skin lesion(s)
- Skin oozing
- Sun sensitivity
- Ulcerations

NEUROLOGY

- Balance difficulty
- Difficulty speaking
- Dizziness
- Fainting
- Gait abnormality
- Headache
- Irritability
- Loss of strength

PSYCH

- Anxiety
- Auditory / visual hallucination
- Delusions
- Depressed mood
- Difficulty sleeping
- Eating disorder
- Loss of appetite
- Mental or physical abuse