

# 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:

Alcoholism \_\_\_\_\_  
 Cancer \_\_\_\_\_  
 Diabetes \_\_\_\_\_  
 Depression \_\_\_\_\_  
 Heart Disease \_\_\_\_\_

High Blood Pressure \_\_\_\_\_  
 High Cholesterol \_\_\_\_\_  
 Obesity \_\_\_\_\_  
 Stroke \_\_\_\_\_  
 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

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

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