Patient Name

PATIENT INTAKE FORM

Please fill in Bubbles Completely

PAST MEDICAL HISTORY		
Diabetes	O Yes	O No
Heart Disease	O Yes	O No
Thyroid Disease	O Yes	O No
Kidney Disease	O Yes	O No
High Blood Pressure	O Yes	O No
Lung Disease	O Yes	O No
Liver Disease	O Yes	O No
Depression	O Yes	O No
Blood Clots	O Yes	O No
Stroke	O Yes	O No
Migraine Headache	O Yes	O No
Asthma	O Yes	O No
Severe Infection	O Yes	O No
Abdominal Pain	O Yes	O No
Bronchitis	O Yes	O No
Eczema	O Yes	O No
Varicose Veins	O Yes	O No
Arthritis	O Yes	O No
Cancer	O Yes	O No
SOCIAL HISTORY		
Alcohol:	O None	O Seldom O Socially O Regularly
Smoking:	O Yes	O No
Drug use:	O Yes	O No
Caffeine:	O Yes	O No
Exercise:	O Yes	O No
Employed:	O Yes	O No

CONSTITUTIONAL		
Fever	O Yes	O No
Weight Loss	O Yes	O No
Weight Gain	O Yes	O No
Chills	O Yes	O No
Weak	O Yes	O No
Body Aches	O Yes	O No

CARDIOLOGY

Chest Pain:

O With exertion O When walking fast O When walking up a hill
O After a heavy meal O When upset or excited O Radiating down the arm
O Relieved at rest O Relieved with Nitro

Irregular Heart Beat O Yes O No

Shortness of Breath:

O While doing usual work O Climbing a flight of stairs O Awakening at night with hunger for air
O Associated with cough O Associated with wheezing
O Associated with blood in sputum O Using more than one pillow

Swelling of the Legs	O Yes	O No
Pain in the calves	O Yes	O No
Leg cramps at night	O Yes	O No
HEMATOLOGY/LYMPH		
Bleeding Tendency	O Yes	O No
History of Leukemia	O Yes	O No
OPHTHALMOLOGY		
Loss of Vision	O Yes	O No
Blurred Vision	O Yes	O No
ENT		
Hearing Loss	O Yes	O No
Sore Throat	O Yes	O No
Hoarseness	O Yes	O No
Sinus Pain	O Yes	O No
Ear Pain	O Yes	O No
Post-nasal Drip	O Yes	O No
Runny Nose	O Yes	O No
UROLOGY		
Blood in Urine	O Yes	O No
Urinary Frequency	O Yes	O No
Difficulty Urinating	O Yes	O No
Urinary Incontinence	O Yes	O No
Burning while urinating	O Yes	O No
Discharge	O Yes	O No

Female Reproductive		
Irregular Menses: O Yes O No O Bleeding between periods O Heavy bleeding during periods		
Pain with Menstruation	O Yes	O No
Abnormal Vaginal Discharge	O Yes	O No
STDs	O Yes	O No
Contraception	O Yes	O No
Pain with Sexual Activity	O Yes	O No
Abnormal Pap	O Yes	O No
Breast Pain O Yes O No O Breast Lump O Nipple Discharge		
Hot Flashes	O Yes	O No
Positive for Menopause	O Yes	O No
Negative for Gardisil	O Yes	O No
Male Reproductive		
Difficulty with Erection	O Yes	O No
Diminished Sexual Drive	O Yes	O No
Penile Discharge	O Yes	O No
STDs	O Yes	O No
Urinary Urgency	O Yes	O No
Dermatology		
Rash	O Yes	O No
Bruising	O Yes	O No
Hives	O Yes	O No

Gastroenterology		
Change in Bowel Habits	O Yes	O No
Abdominal Pain	O No O Related to meals O Relieved by antacids O Relieved by bowel movements O Causes awakening at night	
Diarrhea	O Yes	O No
Vomiting	O Yes	O No
Constipation	O Yes	O No
Blood in Stool	O Yes	O No
Hemorrhoids	O Yes	O No O Bleeding O Inflamed
Musculoskeletal		
Pain with movement	O Yes	O No
Joint Pain:	O Shoulder O Elbow O Wrist O Legs O Knee O Neck O Lower back	
Joint Swelling	O Yes	O No
Muscle Aches	O Yes	O No
Neurology		
Headache	O Yes	O No
Paralysis	O Yes	O No
Weakness	O Yes	O No
Dizziness	O Yes	O No
Seizures	O Yes	O No
Memory Problems	O Yes	O No
Psychology		
Depression	O Yes	O No
Anxiety	O Yes	O No
Mood Swings	O Yes	O No
Sleep Problems	O Yes	O No
Suicidal Ideations	O Yes	O No
Positive for Suicidal Attempts	O No	O Yes O Distant past O Recent
Additional Information		
Do you have an Advance Directive	O Yes	O No
Are you an organ donor	O Yes	O No