PATIENT INTAKE FORM

Date of appointment: _____ **Account #:** _____

Name: _____ Date of birth: _____

Address: _____ Phone (home): _____

_____

Social security number: _____ Phone (cell): _____

Primary insurance: _____ Phone (work): _____

Policy number: _____ Email: _____

Secondary insurance: _____

Policy number: _____

Emergency contact: _____ Emergency contact phone: _____

REASON FOR ESTABLISHING CARE AND ANY PARTICULAR SYMPTOMS OR CONCERNS:

DRUG ALLERGIES (and reaction) and DRUG INTOLERANCES

PRESCRIPTION MEDICATIONS (name, dose, frequency)

NON-PRESCRIPTION MEDICATIONS (name, dose, frequency)

PAST MEDICAL AND SURGICAL HISTORY (any long term medical issues or prior procedures)

SOCIAL HISTORY

Marital status: _____ Children: _____

Occupation: _____

Tobacco Use (never, former, current - with amount, year of onset and/or year of quitting):

_____

Alcohol Use: _____

Family History:

Relationship	Age	Sex	Medical Problems	If Deceased: Age at Death	If Deceased: Cause
Father					
Mother					
Brothers/Sisters					
Children					

Review of Symptoms:

Have you recently had any of the following problems? (please check all that apply.)

Constitutional	Skin	Gastrointestinal	Genitourinary	Ear/Nose/Mouth/Throat
☐ Fever	☐ Rash	☐ Abdominal pain	☐ Difficulty Urinating	☐ Ear Infection
☐ Chills	☐ Itch	☐ Diarrhea	☐ Painful Urination	☐ Sore Throat
☐ Headache	☐ ulcer on feet	☐ Constipation	☐ Frequent urination	☐ Sinus Problem
☐ Major Weight Change	☐ Unexplained Hair loss	☐ Nausea/Vomiting	☐ Blood in urine	☐ Difficulty Swallowing
☐ Appetite Loss		☐ Heartburn	☐ Urinate more than twice at night	☐ Hoarseness
☐ Snoring		☐ Mucous in the stool		
☐ Stop Breathing during sleep		☐ Blood in Stool		
☐ Sleep on more than 1 pillow				

Cardiovascular	Respiratory	Musculoskeletal	Hematologic/Lymphatic	Eyes
☐ Chest Pain	☐ Wheezing	☐ Joint Pain	☐ Swollen Glands	☐ Blurred Vision
☐ High Blood Pressure	☐ Cough	☐ Neck Pain	☐ Blood clotting Problems	☐ Double Vision
☐ Controlled	☐ Shortness of breath	☐ Back Pain	☐ Unexplained bruising	☐ Eye Pain
☐ Uncontrolled	☐ With exertion	☐ leg/hip Pain when Walking		☐ Cataracts
☐ Varicose veins	☐ without exertion			☐ Glaucoma
☐ Swelling in ankles/Feet	☐ Asthma			
	☐ Emphysema			

Neurological	Allergic/Immunologic	Phycological	Endocrine
☐ Tremors	☐ Allergies	☐ Depression	☐ Thyroid Problems
☐ Dizziness	☐ Hay Fever	☐ Anxiety	☐ Hot Flashes
☐ Numbness		☐ Unusual Stress	☐ Cold Intolerance
☐ Arm/leg Weakness		☐ Eating Disorder	
		☐ Suicide Attempt	

HEALTH MAINTENANCE

Vaccinations: Influenza: ___/___/___

Zostavax (shingles): ___/___/___

Shingrx (shingles): ___/___/___; ___/___/___

Prevnar (pneumococcal): ___/___/___

Pneumovax (pneumococcal): ___/___/___

dT (tetanus): _ __/___/___

TDAP (tetanus/pertussis): ___/___/___

Colonoscopy: ___/___/___

PSA (prostate blood test): ___/___/___ (men only)

Mammogram: ___/___/___ (women only)

DEXA (bone density): ___/___/___

Have you ever been screened for hepatitis C? _____

Any additional vaccinations and dates: _____