PATIENT HISTORY AND INTAKE FORM

PATIENT NAME: ____ DOB: __________

DRUG ALLERGIES: Penicillin. Sulfa. Macrolides. Cephalosporin. Tetracyclines. NSAID.

OTHER: ____

OFFICE ONLY					
WT: __________	HT: __________	TEMP: __________	BP: __________	HR: __________	O2: __________

YOUR PAST MEDICAL HISTORY			
Condition	*Year began*	*Condition*	*Year began*
Diabetes		Hypertension	
Renal Disease (kidney disease)		High Cholesterol	
COPD, Bronchitis, Emphysema or Asthma		Hypothyroidism (low thyroid)	
Coronary Artery Disease/ Heart Attack		Depression or Anxiety	
CHF (Heart Failure)		GERD or Peptic Ulcers	
Pacemaker /Defibrillator		Cirrhosis or Hepatitis	
A FIB or Mechanical Valve (type)		Rheumatoid Arthritis	
PVD, PAD, or DVT		Gout or Osteoarthritis	
Stable Chest Pain (using Nitro)		Erectile Dysfunction or BPH	
Stroke or TIA		Sleep Apnea	
Seizure, Parkinson Disease, Epilepsy		Cataracts or Glaucoma	
Dementia or Alzheimer Disease		Cancer	
History of STD's			
Other:			

REVIEW OF SYMPTOMS

Please review the following symptoms and check those items that are a problem for you in the past 3-6 months

Vision problems	Wheezing	Loud Snoring	Spinning/ Vertigo	Diarrhea
Hearing problems	Cough/Coughing blood	Breast Lumps/9ischarge	Memory Loss	Constipation
Sinus trouble	Shortness of breath	Testicle Lump	Balance problems	Rectal bleeding
Hay fever	TB exposure	Frequent Urination	Trouble swallowing	Dark Colored Stool
Nosebleeds	Palpitations	Incontinence	Excessive hunger	Hives
Sore throat	Chest pain / discomfort	Blood in Urine	Excessive thirst	Rash
Hoarseness	Dizziness	Kidney stones	Heat /Cold intolerance	Please' List Others Below:

Lumps in neck	Leg Swelling	Anemia	Excessive Sweating	
Tooth problems	Poor Circulation	Easy bruising	High blood sugar	
Earache/ Discharge	Cold / burning Feet	Joint pain / stiffness	Low blood sugar readings	
Runny Nose/Congestion	Discomfort in legs when walking	Tremor	Nausea	
Fever, I Chills	Weakness	Fainting	Vomiting	
Weight loss / gain	Difficulty sleeping	Weakness	Decrease/ Increased Appetite	
Sweats/ Fatigue	Increased daytime sleepiness	Hallucinations	Abdominal Pain	
Anxiety/Depression	Falling asleep watching TV	Headaches	Heartburn	

FAMILY HEALTH HISTORY

Please list below the health history of your blood (genetic) first degree relatives

Relative	*Living or Deceased*	*Current age or age at death*	*Cause of Death*	*Health Problems*
Father:				
Mother:				
Brother(s):				
Sister(s):				
Mother's Father				
Mother's Mother				
Father's Father				
Father's Mother				
Child{ren)				
I was adopted				
Other:				

HOSPITALIZATIONS WITHIN THE PAST ONE (1) YEAR

Hospitalization Reason	*Month/Yr.*	*Name of Hospital*	*Month/Yr.*

PAST SURGICAL PROCEDURES

Operation Type	*Month/Yr.*	*Operation Type*	*Month/Yr.*
1.		4.	
2.		5.	
3.		6.	

DISEASE PREVENTION AND HEALTH MAINTENANCE Please list below the most recent dates of your vaccines and health screening tests					
	Month/Yr.		*Month/Yr.*		*Month/Yr.*
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine		Pap Smear		Heart Catheterization	
Tetanus Vaccine		Bone Density (DEXA)		ECHO	
Hepatitis B Vaccine		Colonoscopy		Heart Stress Test	
Shingles Vaccine		Endoscopy (EDG)		PSA	
Chest X-Ray		Other:			

MEDICATIONS, VITAMINS AND HERBAL SUPPLEMENTS (If you have a list, you do not need to write this out)					
Medication Name	*Strength (Mg)*	*Number of pills taken & frequency*	*Medication Name*	*Strength (Mg)*	*Number of pills taken & frequency*

SOCIAL, EDUCATIONAL AND WORK HISTORY

Marital Status: Single. Married. Divorced. Widowed.	In what type of residence do you live: Apartment. House. Assisted Living. Nursing Home
Work Status: Employed. Unemployed. Retired. Disabled. Student.	Current/ Prior occupation:

Do you drink alcohol? Yes. No. Not anymore. Never.

What type of alcohol? ____________ No. of drinks per day? _________

I am a social drinker: Yes. No. I am a recovering alcoholic: Yes. No.
I quit drinking (date): __________________

Are you a current smoker? Yes. No. What do you smoke: Cigarettes. Cigars. Pipe.

How much per day? _______________

Former smoker? Yes. No. If so, what year did you quit: ___________.

Number of years you smoked: ______. Pks per day: ___________.

Do you use smokeless tobacco: Y N	Do you use illicit substances: Y N	Cocaine Marijuana Other:
Are you sexually active: Y N	Do you have sex with: Men Women Both	How many partners have you had during the past 12 months?

ADL'S: I CAN DO / KNOW THE FOLLOWING:			
BATHE MYSELF: YES NO	CLEAN MY HOUSE: YES NO	CONTROL BLADDER: YES NO	CONTROL MY BOWEL: YES NO
COOK / PREPARE MEALS: YES NO	CONVERSATE MEANINGFULLY: YES NO	DRESS MYSELF: YES NO	OPERATE MOTOR VEHICLE: YES NO
FEED MYSELF: YES NO	FIND MY WAY HOME: YES NO	LIVE INDEPENDENTLY: YES NO	RECOGNIZE FAMILIAR FACES: YES NO
REMEMBER MY NAME: YES NO	KNOW WHERE I LIVE: YES NO	KNOW THE CURRENT DATE: YES NO	I USE PUBLIC TRANSPORTATION: YES NO

OTHER PHYSICIANS AND SPECIALISTS		
Type of Doctor	*Name of Doctor*	*Phone number:*
Cardiologist		
Dermatologist		
E/N/T		
Gastroenterologist		
Nephrologist		
Oncologist		
Ophthalmologist		
Orthopedist		
Psychiatrist/ Psychologist		
Pulmonologist		
Rheumatologist		
Urologist		
Last Primary Care		
Other:		