Name: LNAME, 'FNAME
DOB: /DOB
Acct #: '/SHAREDID
Age: #VALUE!
Date: 3/24/2015

Patient Intake Form

Patient Information

Patient's Full Name ____________ Date ________ ☐ Male ☐ Female

Date of Birth ____________ Age ______ **Height:** ______ **Weight:** ______

Employer: ____________ Years employed with current employer ______

Health Information

Past Medical History:

Have you had any medical problems? ☐ Yes ☐ No

High Blood Pressure	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Gastritis/Ulcers	☐ Yes	☐ No
Asthma/Emphysema	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No
Other	☐ Yes	☐ No ________

Past Surgical History:

Please list any surgeries you've had.

________ Date ________
________ Date ________
________ Date ________

Social History:

Former tobacco user: ☐ No ☐ Yes(smoker) ☐ Yes(other)
Date Began Smoking: ________ Date Quit Smoking: ________
Current Tobacco Use: ☐ Yes ☐ No Packs per day ________
Alcohol ☐ Yes ☐ No Amount ________
Past or present chemical dependency ☐ Yes ☐ No

Medications, Vitamins, and Supplements:

List all medications you are currently taking. ☐ **None**

- ________
  Dosage ________ **Frequency** ________
- ________
  Dosage ________ **Frequency** ________
- ________
  Dosage ________ **Frequency** ________
- ________
  Dosage ________ **Frequency** ________

Allergies:

List all drugs to which you are allergic. ☐ **None Known**

- ________ Reaction ________
- ________ Reaction ________
- ________ Reaction ________

Family History:

Has anyone in your family had any of these conditions?

Stroke	☐ Yes	☐ No	Mother	Father	Sibling
Heart Disease	☐ Yes	☐ No	Mother	Father	Sibling
Cancer	☐ Yes	☐ No	Mother	Father	Sibling
Other	☐ Yes	☐ No ________			

Hobbies: ________

Review of Systems:

Constitutional/General:

Weight Gain/Loss	☐ Yes	☐ No
Fever	☐ Yes	☐ No

Cardiovascular:

Chest Pain	☐ Yes	☐ No
Irregular Heart Beat	☐ Yes	☐ No
Poor Circulation	☐ Yes	☐ No

Neurological:

Paralysis	☐ Yes	☐ No
Frequent Headaches	☐ Yes	☐ No

Respiratory:

Shortness of breath	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Persistent Cough	☐ Yes	☐ No

Eyes:

Decreased Vision	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No

Gastrointestinal:

Stomach Pain	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Persistent Vomiting	☐ Yes	☐ No

Hematological:

Bleeding Problems	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No
Blood Clots	☐ Yes	☐ No

Psychiatric:

Bipolar Disease	☐ Yes	☐ No
Depression	☐ Yes	☐ No

Ears, Nose, Throat:

Loss of hearing	☐ Yes	☐ No
Sinus problems	☐ Yes	☐ No

Allergies:

Foods	☐ Yes	☐ No
Adhesive, dye, iodine	☐ Yes	☐ No

Musculoskeletal:

Joint Swelling	☐ Yes	☐ No
Joint Pain	☐ Yes	☐ No
Muscle Aches	☐ Yes	☐ No

Endocrine:

Thyroid Problems:	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Other		

Skin:

Rash	☐ Yes	☐ No
Dryness of skin	☐ Yes	☐ No

Genitourinary:

Blood in urine	☐ Yes	☐ No
Pain with urination	☐ Yes	☐ No

Patient/Guardian Signature: ____________ **Date:** ________

Reviewed by: ________ **Initials** ________ **Date** ________
Reviewed by: ________ **Initials** ________ **Date** ________

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