

PATIENT INTAKE HISTORY

| | | | |
|--|-----------------|----------|-----------|
| Patient Name: | Birth Date: / / | SSN: - - | Date: / / |
| Name you would like to use: | | | |
| Why have you come to the office today? | | | |
| Is this a new problem: | | | |
| Whom may we thank for referring you to our office: | | | |

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.

KNOWN ALLERGIES

| Type (Medication or Other) | Reaction |
|----------------------------|----------|
| 1. | 1. |
| 2. | 2. |

IMMUNIZATIONS/ TEST

| | Date | | Date |
|-------------------------------------|------|---------------------------------------|------|
| Tetanus-Diphtheria Booster | | Influenza Vaccine (Flu Shot) | |
| Hepatitis A Vaccine | | Hepatitis B Vaccine | |
| Varicella Vaccine | | Pneumococcal Vaccine | |
| Measles-Mumps-Rubella (MMR) Vaccine | | Tuberculosis (TB) Skin Test - Result: | |

FAMILY HISTORY

| | | | |
|--|------------------|--|------|
| Mother: <input type="checkbox"/> Living <input type="checkbox"/> Deceased - Cause: | Age: | Father: <input type="checkbox"/> Living <input type="checkbox"/> Deceased - Cause: | Age: |
| Siblings: Number Living: | Number Deceased: | Cause(s)/Age(s): | |
| Children: Number Living: | Number Deceased: | Cause(s)/Age(s): | |

| Illness | Yes | Which Relative(s) and Age of Onset | Physician's Notes |
|------------------------------|--------------------------|------------------------------------|-------------------|
| Diabetes | <input type="checkbox"/> | | |
| Stroke | <input type="checkbox"/> | | |
| Heart Disease | <input type="checkbox"/> | | |
| Blood Clots in Lungs or Legs | <input type="checkbox"/> | | |
| High Blood Pressure | <input type="checkbox"/> | | |
| High Cholesterol | <input type="checkbox"/> | | |
| Osteoporosis (Weak Bones) | <input type="checkbox"/> | | |
| Hepatitis | <input type="checkbox"/> | | |
| HIV/AIDS | <input type="checkbox"/> | | |
| Tuberculosis | <input type="checkbox"/> | | |
| Birth Defects | <input type="checkbox"/> | | |
| Drinking or Drug Problems | <input type="checkbox"/> | | |
| Breast Cancer | <input type="checkbox"/> | | |
| Colon Cancer | <input type="checkbox"/> | | |
| Ovarian Cancer | <input type="checkbox"/> | | |
| Uterine Cancer | <input type="checkbox"/> | | |
| Mental Illness/ Depression | <input type="checkbox"/> | | |
| Alzheimer's Disease | <input type="checkbox"/> | | |
| Other | <input type="checkbox"/> | | |

PERSONAL PAST HISTORY OF ILLNESSES

| Major Illnesses | Yes (Date) | No | Not Sure | Physician's Notes |
|---------------------------|------------|----|----------|-------------------|
| Asthma | | | | |
| Pneumonia/ Lung Disease | | | | |
| Kidney Infections/ Stones | | | | |
| Tuberculosis | | | | |

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PERSONAL PAST HISTORY OF ILLNESSES (cont)

| Major Illnesses | Yes (Date) | No | Not Sure | Physician's Notes |
|---|------------|----|----------|-------------------|
| Sexually Transmitted Disease | | | | |
| HIV/ AIDS | | | | |
| Heart Attack/Problems | | | | |
| Diabetes | | | | |
| High Blood Pressure | | | | |
| Stroke | | | | |
| Rheumatic Fever | | | | |
| Blood Clots in Lungs or Legs | | | | |
| Eating Disorders | | | | |
| Collagen Vascular Disease (Lupus) | | | | |
| Chickenpox | | | | |
| Cancer | | | | |
| Reflux/ Hiatal Hernia/ Ulcers | | | | |
| Depression/ Anxiety | | | | |
| Anemia | | | | |
| Blood Transfusions | | | | |
| Seizures/ Convulsions/ Epilepsy | | | | |
| Bowel Problems | | | | |
| Glaucoma | | | | |
| Cataracts | | | | |
| Arthritis/ Joint Pain/ Back Problems | | | | |
| Broken Bones | | | | |
| Hepatitis/ Yellow Jaundice/ Liver Disease | | | | |
| Thyroid Disease | | | | |
| Gallbladder Disease | | | | |
| Headaches | | | | |
| Other | | | | |

OPERATIONS/HOSPITALIZATIONS

| Reason | Date | Hospital |
|--------|------|----------|
| | | |
| | | |
| | | |
| | | |

SOCIAL HISTORY

| | | | | | |
|---|------------------------------------|---|------------------------------------|-----------------------------------|--------------------------------------|
| Marital Status | <input type="checkbox"/> Single | <input type="checkbox"/> Married | <input type="checkbox"/> Separated | <input type="checkbox"/> Divorced | <input type="checkbox"/> Widowed |
| Ethnicity | <input type="checkbox"/> Caucasian | <input type="checkbox"/> African American | <input type="checkbox"/> Hispanic | <input type="checkbox"/> Asian | <input type="checkbox"/> Other _____ |
| | | | Yes | No | Physician Notes |
| Do you currently smoke? _____ Packs Per Day – For _____ Years | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Do you currently drink alcohol? _____ Drinks Per Day - _____ Times Per Week | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Recreational Drug Use | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Regular Exercise? How Long _____ How Often? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Dairy Product Intake/ Calcium Supplements: Quantity | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Have You Been Sexually Abused, Threatened, or Hurt By Anyone? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

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GYNECOLOGIC HISTORY

| | |
|---|------------------|
| | Physicians Notes |
| Last normal menstrual period (First Day): / / | |
| Age periods began: | |
| Length of periods (number of days bleeding): | |
| Number of days between periods: | |
| Any recent changes in periods? | |
| Are you currently sexually active? | |
| Have you ever had sex? | |
| Number of sexual partners (lifetime): | |
| Sexual partners are <input type="checkbox"/> male <input type="checkbox"/> female <input type="checkbox"/> both | |
| Present method of birth control: | |
| Have you ever used an intrauterine device (IUD) or birth control pills? | |
| If yes, for how long? | |
| When was your last pap test? | |
| What was the result? | |
| Have you ever had an abnormal pap test? | |
| Do you do regular breast self-examinations? | |
| When was your last Mammogram: / / | |

CURRENT MEDICATIONS

(Including hormones, vitamins, herbs, nonprescription medications)

| Drug Name | Dosage | Who Prescribed | Drug Name | Dosage | Who Prescribed |
|-----------|--------|----------------|-----------|--------|----------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

PREFERRED PHARMACY

| | |
|---------|--------|
| Name | Phone# |
| Address | |

OBSTETRIC HISTORY

| | | Number | | | | Number | |
|---|------------|-----------------|------------|----------------|--------------------------------------|-----------------|--|
| Pregnancies | | | | Abortions | | | |
| Premature Birth (<37 weeks) | | | | Live Births | | | |
| | | | | | | Miscarriages | |
| | | | | | | Living children | |
| NO. | Birth Date | Weight at Birth | Baby's Sex | Weeks Pregnant | Type of Delivery (vaginal, cesarean) | Complications? | |
| 1. | | | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |
| Physician's Notes on Obstetric History: | | | | | | | |
| | | | | | | | |
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REVIEW OF SYSTEMS

(Please indicate if any of the following symptoms apply to you now or since adulthood)

| | Now | Past | Unsure | | Now | Past | Unsure |
|----------------------------------|--------------------------|--------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|
| 1. Constitutional | | | | Involuntary/Unintended Urine Loss | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Weight Loss | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Urine Loss when Coughing or Lifting | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Weight Gain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Bleeding | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fever | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Painful Periods | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fatigue | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Premenstrual Syndrome (PMS) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Change in Height | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Painful Intercourse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Eyes | | | | Fibroids | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Double Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Infertility | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Spots Before Eyes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | DES Exposure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Vision Changes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Vaginal Discharges | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Glasses/ Contacts | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 8. Musculoskeletal | | | |
| 3. Ear, Nose and Throat | | | | Muscle Weakness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Earaches | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Muscle or Joint Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ringing in Ears | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 9. Skin | | | |
| Hearing Problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rash | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus Problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sores | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sore Throat | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dry Skin | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mouth Sores | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Moles | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dental Problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 10. Breasts | | | |
| 4. Cardiovascular | | | | Pain in Breast | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Painful Breathing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nipple Discharge | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest Pain or Pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lumps | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty Breathing on Exertion | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 11. Neurologic | | | |
| Swelling of Legs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Rapid or Irregular Heartbeat | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Seizures | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Respiratory | | | | Numbness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Wheezing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Trouble Walking | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Spitting up Blood | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Severe Memory Problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Shortness of Breath | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent or Severe Headaches | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chronic Cough | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 12. Psychiatric | | | |
| 6. Gastrointestinal | | | | Depression or Frequent Crying | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Severe Anxiety | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bloody Stool | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 13. Endocrine | | | |
| Nausea/Vomiting/Indigestion | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hair Loss | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Constipation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heat/ Cold Intolerance | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Involuntary Loss of Gas or Stool | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Thirst | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Genitourinary | | | | Hot Flashes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood in Urine | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 14. Hematologic/Lymphatic | | | |
| Pain with Urination | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Bruises | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Strong Urgency to Urinate | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cuts Do Not Stop Bleeding | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent Urination | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Enlarged Lymph Nodes (Glands) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Incomplete Emptying | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | |

| | |
|-------------------|------|
| Patient Signature | Date |
|-------------------|------|