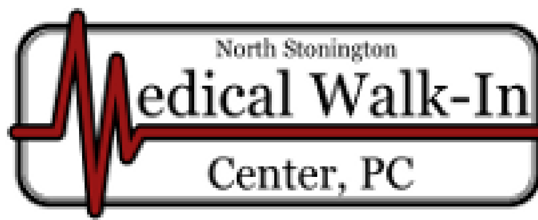

2012 Patient Intake Form

Patient:________________________________ **D.O.B**_______________ **Date:**________________

Occupation:_________________________________	List all allergies:___________________________
Employer:__________________________________	_______________________________________
Race_______________________________________	List all medications you are currently taking (include non-
Ethnicity: Hispanic_____ Non-Hispanic______	prescription drugs) _________________________
Primary language ____________________________	_______________________________________
Marital Status:______________________________	_______________________________________
Exercise Y/N How frequently?__________________	List all serious medical incidents (ie.-surgery, illness, accident, head injury, and hospitalizations) :
Smoking Y/N amt.per day______________________	_______________________________________
Former Smoker Y/N Date quit _________________	_______________________________________
Alcohol Y/N Type/amt. per day_________________	Date of last physical exam :____________________
Caffeine Y/N type/ amt .per day________________	Primary Care physician: _______________________
Drugs Y/N type/amt per day___________________	Date of last dental exam:______________________
History of family violence?_____________________	Preferred pharmacy & town____________________

Past Medical History (Check Yes or No)

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Measles			Venereal Disease			Anemia		
Mumps			Infectious Mono			Asthma		
Chicken Pox			Hepatitis			Thyroid Disease		
Tuberculosis			Heart Disease			Kidney Disease		
Polio			Cardiac Episode			Arthritis		
Diphtheria			Hypertension			Seizures/Epilepsy		
Rheumatic Fever			High cholesterol			Migraine		
Scarlet fever			Diabetes/type			Depression		
Whooping Cough			Stroke			Glaucoma		
Pneumonia			Mitral Valve Prolapse			Hernia		
Lyme Disease			Low blood pressure			Other:		
HIV/Aids			Transfusion					

Family History: Has a blood relative had any of the following (Check Yes or No)

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Heart Disease			Anemia			Cancer/Type		
Hypertension			Allergies			Seizures		
Stroke			Asthma			Gout		
High Cholesterol			Lung Disease			Depression		
Diabetes/Type			Kidney Disease			Drug/alcohol abuse		
Obesity			Thyroid Disease			Glaucoma		

OVER →

Patient Name:______________________________ DOB_____________________________

Do you have, or have you had in the past year:

Condition	Yes	No	Condition	Yes	No	Provider Review
Constitutional			**Respiratory**			For office use only:
Weakness			Chronic cough			Date / Initial
Tiredness			Shortness of breath			
Weight Change			Wheezing			
Change in appetite			**Musculoskeletal**			
Eyes			Backache			
Double/blurred vision			Joint pain			
Glasses/contacts			Joint stiffness			
Last eye exam:			Joint swelling			
Ears/Nose/Throat			Muscle cramps			
Ringing in ears			Swelling hand/feet			
Frequent nose bleeds			**Skin/breasts**			
Sinus problems			Skin rash			
Loss of smell			Breast lump			
Sore throat			Nipple discharge			
Cardiac/vascular			**Neurological**			
Palpitations			Poor coordination			
Heart flutter			Dizziness			
Chest pain			Seizure			
Genitourinary			Fainting			
Frequent urination AM / PM			**Endocrinology**			
Painful urination			Increased thirst			
Leakage of urine			**Psychological**			
Blood in urine			Depression			
Women only: Do you experience			Memory loss			
Heavy bleeding during periods			**Gastrointestinal**			
Painful intercourse			Difficulty swallowing			
Bleeding/spotting between periods			Frequent belching			
Pain or cramping in abdomen			Abdominal cramping			
Age period began			Vomiting/nausea			
# of days period lasts			Chronic diarrhea			
Days between periods			Chronic constipation			
Date of last pelvic/pap			Rectal bleeding			
Date of last mammogram			Hemorrhoids			
Birth control/type			**Men only: Do you experience**			
Number of pregnancies			Discharge from penis			
Number of full term births			Lump/pain in testicles			
Number of preterm births			Impotence			
Number of miscarriages			Painful intercourse			

Please list all other concerns not addressed in this questionnaire

I have answered all parts of this questionnaire and have included my complete and accurate medical information and history to the best of my knowledge.

_______________________________________ ______________________

Signature of Patient (or responsible party) Date