

**PATIENT INTAKE HISTORY**

**DATE:** \_\_\_\_\_

NAME: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_

CITY/STATE/ZIP \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

HOW REFERRED: \_\_\_\_\_

PRIMARY CARE PHYSICIAN NAME/PHONE # \_\_\_\_\_

OTHER DRS.: \_\_\_\_\_

**Please (x) appropriate box if any of the following apply to you NOW and explain**

<u>TITLE</u>	<u>Current</u>	<u>NOTES</u>	<u>TITLE</u>	<u>Current</u>	<u>NOTES</u>
<b>1. <u>Constitutional</u></b> Weight Loss _____ Weight Gain _____ Fever _____ Fatigue _____	_____ _____ _____ _____	_____ _____ _____ _____	<b>8. <u>Musculoskeletal</u></b> Muscle Weakness _____ Joint Pain _____ Back Pain _____ Neck Pain _____	_____ _____ _____ _____	_____ _____ _____ _____
<b>2. <u>Eyes</u></b> Double Vision _____ Spots before Eyes _____ Vision Changes _____	_____ _____ _____	_____ _____ _____	<b>9. <u>Psychiatric</u></b> Depression _____ Anxiety _____ Psychiatric Diagnosis _____	_____ _____ _____	_____ _____ _____
<b>3. <u>Ear/Nose/Throat</u></b> Ear Aches _____ Ringing in Ears _____ Sinus Problems _____ Sore Throat _____ Mouth Sores _____ Dental Problems _____	_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____	<b>10. <u>Neurological</u></b> Dizziness _____ Seizures _____ Numbness _____ Trouble Walking _____ Memory Problems _____ Headaches _____	_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____
<b>4. <u>Cardiovascular</u></b> Breathing Problems _____ Chest Pain _____ Pain with Exertion _____ Exertion Short Breath _____ Swelling of Legs _____ Heart Palpitations _____	_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____	<b>11. <u>Breast/Skin</u></b> Pain _____ Discharge _____ Masses _____ Skin Rash _____ Changing Moles _____	_____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____
<b>5. <u>Respiratory</u></b> Wheezing _____ Spitting up Blood _____ Shortness of Breath _____ Chronic Cough _____	_____ _____ _____ _____	_____ _____ _____ _____	<b>12. <u>Endocrine</u></b> Dry Skin _____ Abnormal Thirst _____ Hot Flashes _____ Thyroid Disorder _____ Diabetes/Prediabetes _____	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____
<b>6. <u>Gastrointestinal</u></b> Diarrhea _____ Blood in Stool _____ Nausea/Vomiting _____ Constipation _____	_____ _____ _____ _____	_____ _____ _____ _____	<b>13. <u>Hematologic/Lymphatic</u></b> Frequent Bruises _____ Cuts Not Healing _____ Enlarged Lymph Nodes _____ Prolonged Bleeding/cuts _____	_____ _____ _____ _____	_____ _____ _____ _____
<b>7. <u>Genitourinary</u></b> Blood in Urine _____ Pain/Urgent Urination _____ Frequent Urination _____ Stress Incontinence _____ Abnormal Bleeding _____ Painful Intercourse _____ Menopausal Symptoms _____	_____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____	<b>14. <u>Allergic/Immunologic</u></b> Allergies (Food) _____ Allergy(Environmental) _____ <b>Drug Allergies</b> (Please list in Notes) _____ Drug Reactions _____ (Please list in Notes) _____ Latex Allergy _____	_____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____

<b>PERSONAL PAST HISTORY</b>			<b>PATIENT NAME</b>			<b>D.O.B.</b>		
<b>MAJOR ILLNESSES</b>	<b>YES</b>	<b>COMMENTS</b>	<b>MAJOR ILLNESSES</b>	<b>YES</b>	<b>COMMENTS</b>			
Asthma	_____	_____	Cancer (LIST TYPE)	_____	_____			
Pneumonia	_____	_____	Ulcers	_____	_____			
Chronic Lung Disease	_____	_____	Hepatitis/Yellow Jaundice	_____	_____			
Tuberculosis	_____	_____	Bowel Trouble	_____	_____			
Kidney Infections/Stones	_____	_____	Depression/anxiety	_____	_____			
Sexually Transmitted Dis.	_____	_____	Anemia/Blood Transfusions	_____	_____			
Heart Trouble/Murmur	_____	_____	Seizures/Convulsions/Epilepsy	_____	_____			
Diabetes/Prediabetes	_____	_____	Glaucoma	_____	_____			
High Blood Pressure	_____	_____	Arthritis/Joint Pain	_____	_____			
Stroke	_____	_____	Fracture	_____	_____			
Rheumatic Fever	_____	_____	Thyroid Disease	_____	_____			

**OB/GYN HISTORY (Put Yes/No or total number applicable)**

Pregnancies \_\_\_\_\_ Births \_\_\_\_\_ Miscarriages \_\_\_\_\_ Abortions \_\_\_\_\_ Living Children \_\_\_\_\_  
 Delivery Date \_\_\_\_\_ Term/weeks \_\_\_\_\_ Sex \_\_\_\_\_ Type of Delivery \_\_\_\_\_ Anesthesia \_\_\_\_\_ Complication/Induced \_\_\_\_\_

Age at first menstrual period \_\_\_\_\_ Are your periods regular? \_\_\_\_\_ How many tampons/pads do you use on a heavy day? \_\_\_\_\_  
 How long do your periods last? \_\_\_\_\_ Do you ever bleed between periods? \_\_\_\_\_ Do you ever bleed after sex? \_\_\_\_\_  
 Do you have any discomfort with your periods? \_\_\_\_\_ Have you stopped having periods? \_\_\_\_\_ Age when periods stopped \_\_\_\_\_

**GYN OR OTHER SURGERY/HOSPITALIZATION HISTORY**

<b>Date</b>	<b>Procedure</b>	<b>Facility</b>	<b>Complications?</b>

**LAST IMMUNIZATION OR TEST (Put date last given)**

Tetanus Shot \_\_\_\_\_ Flu Shot \_\_\_\_\_ TB Skin Test \_\_\_\_\_ Pneumonia Shot \_\_\_\_\_

**CURRENT MEDICATIONS (List Drug Name and Dosage)**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**FAMILY HISTORY (Please (x) if any of the following applies to a family member and state relationship (i.e. mom, dad, etc))**

<b>ILLNESS</b>	<b>YES</b>	<b>FAMILY MEMBER</b>	<b>ILLNESS</b>	<b>YES</b>	<b>FAMILY MEMBER</b>
Diabetes	_____	_____	Drinking Problem	_____	_____
Stroke	_____	_____	Breast Cancer	_____	_____
Heart Disease	_____	_____	Colon Cancer	_____	_____
High Blood Pressure	_____	_____	Ovarian Cancer	_____	_____
Lung Cancer	_____	_____	Osteoporosis	_____	_____
High Cholesterol	_____	_____	Other	_____	_____

**SOCIAL HISTORY/PERSONAL HABITS (Please indicate yes/no and applicable information)**

Smoking \_\_\_\_\_ Packs Per Day: \_\_\_\_\_ Years: \_\_\_\_\_ Seat Belt Use \_\_\_\_\_  
 Alcohol Use \_\_\_\_\_ Drinks Per Day: \_\_\_\_\_ Per Wk: \_\_\_\_\_ Drug Use \_\_\_\_\_  
 Diet \_\_\_\_\_ Exercise Type \_\_\_\_\_ # Times Per Wk \_\_\_\_\_

**PERSONAL SAFETY**

Has anyone close to you verbally or physically hurt you? Yes \_\_\_\_\_ No \_\_\_\_\_ Comments: \_\_\_\_\_  
 Has anyone, including your partner, ever forced you to have sex? Yes \_\_\_\_\_ No \_\_\_\_\_ Comments: \_\_\_\_\_  
 Have you ever been afraid of your partner? Yes \_\_\_\_\_ No \_\_\_\_\_ Comments: \_\_\_\_\_

**HIGH RISK CRITERIA (Please check yes/no and date if applicable)**

Have you ever had a Pap smear? Yes \_\_\_\_\_ No \_\_\_\_\_ DATE of Last Pap Smear Test \_\_\_\_\_  
 Have you ever had an abnormal Pap smear test? Yes \_\_\_\_\_ No \_\_\_\_\_ DATE \_\_\_\_\_ TREATMENT \_\_\_\_\_  
 Did you begin sexual activity before you were 16 years old? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Have you had more than 5 sexual partners in your lifetime? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Do you have sex with men, women or both? \_\_\_\_\_  
 Have you ever been tested for the HIV virus? Yes \_\_\_\_\_ No \_\_\_\_\_ DATE \_\_\_\_\_ RESULTS \_\_\_\_\_  
 Did your mother take the drug DES when she was pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_ DATE \_\_\_\_\_

Signature of Patient

Signature of Provider

Date First Reviewed

Annual History Review - Date/Sign

Annual History Review - Date/Sign

Annual History Review - Date/Sign