

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

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.							
5.							

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
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