Patient Intake Form

Your answers to the following questions help us to understand your medical/health history. Please fill out as much of the form as possible. If you cannot answer some of the questions or feel uncomfortable answering them, leave them blank.

Name _____ Date of birth _____ Gender _____
Today's date _____Primary care/Referring provider_____
Reason for your visit _____
Are you having any pain today? Yes___ No___ Where? _____Pain scale 1-10 ____
Age _____ Height _____ Weight _____ Date of last physical exam_____
Preferred Pharmacy _____
Occupation _____Who do you live with? _____
Height _____ Weight_____ Temp _____ Pulse_____ Resp _____B/P _____ O2 sat _____

Medication	**Dosage**

Supplements	**Dosage**

Allergies

Please list all allergies Medications, food, environmental, etc
_____Check if No Allergies

Allergy	**Reaction**

Name_____

Routine Health Care

Female:

Date of last pap smear: _____ Result: _____ Normal _____ Abnormal
Date of last mammogram: _____ Result: _____ Normal _____ Abnormal
Date of last colon screening: _____ Result: _____ Normal _____ Abnormal
Have you had bone density? _____ Result: _____ Normal _____ Abnormal
Date of last eye exam: _____ Result: _____ Normal _____ Abnormal
Date of last dental exam: _____ Result: _____ Normal _____ Abnormal

Male:

Date of last prostate exam: _____ Result: _____ Normal _____ Abnormal
Date of last PSA blood test: _____ Result: _____ Normal _____ Abnormal
Date of last colon screening: _____ Result: _____ Normal _____ Abnormal
Have you had bone density? _____ Result: _____ Normal _____ Abnormal
Date of last eye exam: _____ Result: _____ Normal _____ Abnormal
Date of last dental exam: _____ Result: _____ Normal _____ Abnormal

Social History & Habits

Smoking (mark one)
_____ I have never smoked
_____ I'm a former smoker When did you quit _____
_____ I'm a current smoker How many years _____ How many packs per day _____
Are you interested in quitting Yes_____ No _____

Smokeless Tobacco (mark one)
_____ I have never used
_____ I'm a former user When did you quit _____
_____ I'm a current user How many years _____ How much per day _____
Are you interested in quitting Yes_____ No _____

Vapping (mark one)
_____ I have never used
_____ I'm a former user When did you quit _____
_____ I'm a current user How many years _____ How much per day _____
Are you interested in quitting Yes_____ No _____

Do you drink alcohol? (mark one)
_____ No
_____ Yes Per week #Glasses of wine _____ #Cans of beer _____ #Shots of liquor _____
Are you interested in quitting Yes_____ No _____

Do you use recreational drugs? (mark one)
_____ No
_____ I'm a former user
_____ Yes Which drugs do you use? _____ Times per week _____
Are you interested in quitting Yes_____ No _____

Have you ever been sexually, physically or emotionally abused? Yes _____ No _____

Name_____

Medical History

Please circle all of the following you have had:

Abnormal Pap smear	COPD	GERD/Acid reflux	Pelvic Pain
Abnormal Uterine Bleeding	Coronary or heart disease	Hepatitis	Pelvic Inflammatory Disease
Anemia	Deep vein thrombosis	HIV	Pulmonary Embolism
Anxiety/ADHD	Depression	Hypertension	Seizures
Arthritis	Diabetes Type 1 Diabetes Type 2	Infertility	Sexually Transmitted Disease
Asthma	Elevated PSA	Kidney Disease	Sleep issues/Apnea
Blood Transfusion	Endometriosis	Lipid or high cholesterol	Stroke
Cancer (explain below)	Fibroids	Migraines/Headaches	Substance Abuse
CHF (heart failure)	Genital Herpes	Musculoskeletal/Neurologic disorders	Thyroid Disease
Clotting disorder	Genital Warts	Osteoporosis	Urinary Issues

Other medical conditions, or additional information about above conditions:

_____
_____
_____
_____

Surgical History

Please circle all of the following you have had, and date performed:

Open abdominal surgery	D&C	Ovary Removal
Appendectomy	Endometrial Ablation	Pelvic Laparoscopy
Bladder suspension	Gallbladder removal	Prostatectomy
Breast Surgery	Hernia Repair	Tonsillectomy
C-section	Removal Fibroids	Tubal Ligation
Cervical dysplasia: (circle) Freezing, LEEP, Conization, Laser	Hysterectomy: (circle) -Abdominal -Laparoscopic -Robotic -Vaginal	Joint surgeries: (circle) Knee replacement Right Left Hip replacement Right Left Shoulder repair Right Left
Colon surgery	Hysteroscopy	Ear surgery Right Left
Cosmetic surgery	Eye surgery Right Left	Vasectomy

Other surgeries and procedures, or additional information about those circled above:

_____
_____
_____
_____

Name_____

Immunizations

Please circle all of the following you have had, and date performed:

Influenza	Meningococcal (MenACWY, MenB)
Tetanus, Diptheria, Pertussis (Tdap, Td)	Measles, Mumps, Rubella (MMR)
Chickenpox (VAR)	Hepatitis A
Shingles (RZV or ZVL)	Hepatitis B
HPV (Human Papilloma)	Pneumococcal (PCV13)
Haemophilus Influenzae (HIB)	Pneumococcal (PPSV23)

Reproductive History Female

How old were you when you had your first period? _____
When was the first day of your last period? _____
Are your periods regular every 25-35 days? _____
I no longer have periods because of (circle): Menopause Hysterectomy Other _____
How many total pregnancies? _____ Miscarriages or terminations _____ Preterm _____ Full-term _____
How many sexual partners have you had in your lifetime? _____ New partner in last 6 months? _____
Are you currently sexually active? Yes ___No ___ Sexual preference? Male ___ Female ___ Other _____
Are you currently using any method of birth control? _____
Are you trying to get pregnant? _____
Any pain, decreased interest, vaginal dryness during intercourse? _____
Any issues with leaking urine? Yes _____ No _____ Any issues with leaking stool? Yes _____ No _____

Reproductive History Male

Have you fathered any children? Yes _____ No by choice_____ No due to other circumstances _____
How many sexual partners have you had in your lifetime? _____ New partner in last 6 months? _____
Are you currently sexually active? Yes ___No ___ Sexual preference? Male ___ Female ___ Other _____
Are you currently using any method of birth control? _____
Are you trying to get pregnant? _____
Any pain, decreased interest or difficulty with an erection during intercourse? _____
Any issues with leaking urine? Yes _____ No _____ Any issues with leaking stool? Yes _____ No _____

Depression Screen

During the past month
Has feeling down bothered you, feeling depressed or hopeless? Yes _____No____
Have you been bothered by little interest or pleasure in doing things? Yes ____No _____

Over the last 2 weeks
Have you been bothered by feeling nervous, anxious or on the edge? Yes _____ No _____
Have you been bothered by not being able to stop or control worrying? Yes _____ No _____

Name_____

Family History

Biological Mother				Biological Father			
Ethnic Background:				Ethnic Background:			
✓ If Living	✓ If in Good Health	Name Current age	Health problems Age diagnosis Cause/age death	✓ If Living	✓ If in Good Health	Name Current age	Health problems Age diagnosis Cause/age death
Maternal Family				**Paternal Family**			
✓ If Living	✓ If in Good Health	Name Current age	Health problems Age diagnosis Cause/age death	✓ If Living	✓ If in Good Health	Name Current age	Health problems Age diagnosis Cause/age death
		Grandma				Grandma	
		Grandpa				Grandpa	
		Aunt				Aunt	
		Aunt				Aunt	
		Uncle				Uncle	
		Uncle				Uncle	
Your Sisters				**Your Brothers**			
✓ If Living	✓ If in Good Health	Name Current age	Health problems Age diagnosis Cause/age death	✓ If Living	✓ If in Good Health	Name Current age	Health problems Age diagnosis Cause/age death
Your Daughters				**Your Sons**			
✓ If Living	✓ If in Good Health	Name Current age	Health problems Age diagnosis Cause/age death	✓ If Living	✓ If in Good Health	Name Current age	Health problems Age diagnosis Cause/age death

Name_____

Symptom Review

General:	Yes	No	**Intestinal:**	Yes	No	**Neurological/psychiatric:**	Yes	No
Weight change	€	€	Blood in stool	€	€	Loss of memory	€	€
Unusual Fatigue	€	€	Constipation	€	€	Weakness in limbs	€	€
Fevers/Chills	€	€	Diarrhea	€	€	Dizziness or passing out	€	€
Loss of appetite	€	€	Abdominal pain	€	€	Numbness or tingling	€	€
Awakening due to pain	€	€	Abdominal bloating	€	€			
Feeling full quickly	€	€	Hemorrhoids	€	€			
			Rectal pain	€	€			
			Rectal bleeding	€	€			
Head/eye/ear/throat:	Yes	No	**Blood/growths:**	Yes	No	**Joints/bones/muscles:**	Yes	No
Changes in eyesight	€	€	Bleeding from gums	€	€	Muscle pain	€	€
Hoarse voice	€	€	Swollen lymph nodes	€	€	Bone pain	€	€
Difficulty swallowing	€	€	Breast lump or pain	€	€	Joint pain	€	€
Difficulty hearing	€	€	Lump or mass elsewhere	€	€	Swollen ankles	€	€
Heart:	Yes	No	**Skin:**	Yes	No	**Glands/endocrine:**	Yes	No
Palpitations	€	€	Rash	€	€	Excessive thirst	€	€
Chest pain	€	€	Non-healing sore	€	€	Heat intolerance	€	€
	€	€	Changing mole	€	€	Cold intolerance	€	€
	€	€	Other concerning lesion	€	€			
Lungs:	Yes	No	**Female Reproductive:**	Yes	No	**Male Reproductive:**	Yes	No
Shortness of breath	€	€	Pelvic pain	€	€	Pelvic pain	€	€
Cough	€	€	Irregular periods	€	€	Sores or lesions	€	€
Coughing up blood	€	€	Heavy periods	€	€	Discharge from penis	€	€
Wheezing	€	€	Bleeding after menopause	€	€	Bleeding from penis	€	€
			Unusual vaginal discharge	€	€	Pain/Burning with urination	€	€
			Pain/Burning with urination	€	€	Frequency of urination	€	€
			Frequency of urination	€	€	Blood in urine	€	€
			Blood in urine	€	€	Loss of urine	€	€
			Loss of urine	€	€	Sores or lesions	€	€
			Sores or lesions	€	€			

Do you have any other health concerns that your provider should know about? If yes, please explain:

_____

_____

_____