

Patient Name: \_\_\_\_\_

## PATIENT INTAKE HISTORY

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

### General Medical History

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Alcohol/drug Addiction | <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Arrhythmia            |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Bleeding disorder     |
| <input type="checkbox"/> Blood clots            | <input type="checkbox"/> Blood transfusions        | <input type="checkbox"/> Bowel problems        |
| <input type="checkbox"/> Broken bones           | <input type="checkbox"/> Cancer                    | <input type="checkbox"/> Cataracts             |
| <input type="checkbox"/> Chickenpox             | <input type="checkbox"/> Collagen vascular disease | <input type="checkbox"/> Depression/anxiety    |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Eating disorder           | <input type="checkbox"/> Gallbladder disease   |
| <input type="checkbox"/> Glaucoma               | <input type="checkbox"/> Headaches                 | <input type="checkbox"/> Heart disease/attacks |
| <input type="checkbox"/> Heart murmur           | <input type="checkbox"/> Hepatitis                 | <input type="checkbox"/> High blood pressure   |
| <input type="checkbox"/> High cholesterol       | <input type="checkbox"/> HIV/AIDS                  | <input type="checkbox"/> Joint/back pain       |
| <input type="checkbox"/> Kidney infections      | <input type="checkbox"/> Kidney stones             | <input type="checkbox"/> Lung disease          |
| <input type="checkbox"/> Osteoporosis           | <input type="checkbox"/> Pneumonia                 | <input type="checkbox"/> Reflux/ulcers         |
| <input type="checkbox"/> Rheumatic fever        | <input type="checkbox"/> Seizures/epilepsy         | <input type="checkbox"/> Sickle cell           |
| <input type="checkbox"/> Stroke                 | <input type="checkbox"/> Thyroid disease           | <input type="checkbox"/> Tuberculosis          |
| <input type="checkbox"/> Other _____            | <input type="checkbox"/> None                      |  |

### Past Surgical/Injury History

None

Date	Surgery/Injury

### Allergies

None

Drug/Food/Other Trigger	Reaction

### Medications (Please include all hormones, vitamins, herbs, and non prescription medications)

None

Drug Name	Dose	Drug Name	Dose

### Social History

**Sexual Orientation:**  Heterosexual  Homosexual  Bisexual

**Marital Status:**  Married  Living with partner  Single  Widowed  Divorced

**Number of people living in your household:** \_\_\_\_\_

**Current or most recent job:** \_\_\_\_\_

**Travel outside the US?** \_\_\_\_\_

**Have you ever smoked?**  Yes  No **Currently smoking:** \_\_\_\_\_ packs per day for \_\_\_\_\_ years

**Alcohol:**  Never  Rarely  Socially \_\_\_\_\_ drinks per day \_\_\_\_\_ drinks per week

**Have you ever used recreational drugs?**  Yes  No **Do you exercise regularly?**  Yes  No

**Please quantify your dairy intake or calcium supplement usage:** \_\_\_\_\_

**Please quantify your daily caffeine intake:** \_\_\_\_\_

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Have you been sexually abused, threatened or hurt by anyone?  Yes  No

**Family History**

**Mother:**  Living  Deceased (cause/age: \_\_\_\_\_)

**Father:**  Living  Deceased (cause/age: \_\_\_\_\_)

**Siblings:** Number living \_\_\_\_\_ Number deceased \_\_\_\_\_ Cause/Age \_\_\_\_\_

**Children:** Number living \_\_\_\_\_ Number deceased \_\_\_\_\_ Cause/Age \_\_\_\_\_

**Family history of the following:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Alcohol/drug Addiction | <input type="checkbox"/> Alzheimer's               | <input type="checkbox"/> Birth Defects        |
| <input type="checkbox"/> Blood clots            | <input type="checkbox"/> Breast Cancer             | <input type="checkbox"/> Colon Cancer         |
| <input type="checkbox"/> Cystic Fibrosis        | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Heart Disease/Attack |
| <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> High Cholesterol     |
| <input type="checkbox"/> HIV/AIDS               | <input type="checkbox"/> Mental Illness/Depression | <input type="checkbox"/> Osteoporosis         |
| <input type="checkbox"/> Ovarian Cancer         | <input type="checkbox"/> Stroke                    | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Uterine Cancer         | <input type="checkbox"/> Thyroid Disorder          | <input type="checkbox"/> Other                |

**Gynecological History**

First day of your last menstrual period \_\_\_\_/\_\_\_\_/\_\_\_\_ Age at your first period \_\_\_\_\_

Usual number of days of bleeding with menses \_\_\_\_\_

How often do you have periods (i.e. every 28 days)? \_\_\_\_\_

Any menstrual abnormalities? \_\_\_\_\_

Age at menopause: \_\_\_\_\_

Have you ever had sex?  Yes  No Are you currently sexually active?  Yes  No

Are your sex partners:  Men  Women  Both  Not applicable

Any history of sexually transmitted diseases? \_\_\_\_\_

Present method of birth control: \_\_\_\_\_

Have you ever used birth control or hormone replacement therapy?  Yes  No

If yes, which and for how long? \_\_\_\_\_

When was your last PAP test? \_\_\_\_\_

Have you ever had an abnormal PAP? \_\_\_\_\_

Do you have regular breast self-exams?  Yes  No Date of last mammogram? \_\_\_\_/\_\_\_\_/\_\_\_\_

**Obstetric History**  None

Please include information about all pregnancies – births, miscarriages, abortions, and ectopic (tubal).

Date	Weight	Sex	Place Delivered	Type of Delivery	Complications

**Immunizations**

Date	Immunization	Date	Immunization
	Tetanus-Diphtheria Booster		Flu Shot
	Pneumococcal Vaccine		Hepatitis B Vaccine
	Varicella Vaccine		Measles-Mumps-Rubella Vaccine

Pharmacy Name: \_\_\_\_\_ Pharmacy Phone number: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

Patient Name: \_\_\_\_\_

## REVIEW OF SYSTEMS

Please check any of the following symptoms that apply to you.

### Constitutional

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Change in height | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Difficulty sleeping |
| <input type="checkbox"/> Fatigue            | <input type="checkbox"/> Fever            | <input type="checkbox"/> Night sweats     | <input type="checkbox"/> Weight loss         |
| <input type="checkbox"/> Weight gain        | <input type="checkbox"/> Other _____      |   |  |

### Eyes

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Double vision | <input type="checkbox"/> Glasses/contacts | <input type="checkbox"/> Spots before eyes |
| <input type="checkbox"/> Vision changes | <input type="checkbox"/> Other _____   |   |  |

### Ear, Nose and Throat

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Congestion                | <input type="checkbox"/> Dental problems          | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Earaches            |
| <input type="checkbox"/> Hearing problems          | <input type="checkbox"/> Mouth sores              | <input type="checkbox"/> Neck mass             | <input type="checkbox"/> Neck stiffness/pain |
| <input type="checkbox"/> Nose bleeds/bleeding gums | <input type="checkbox"/> Recurrent ear infections | <input type="checkbox"/> Ringing in ears       | <input type="checkbox"/> Runny nose          |
| <input type="checkbox"/> Seasonal allergies        | <input type="checkbox"/> Sinus problems           | <input type="checkbox"/> Sore throat           |  |
| <input type="checkbox"/> Other _____               |   |  |  |

### Cardiovascular

- |   |   |   |                                       |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Chest pain or pressure             | <input type="checkbox"/> Leg pain       | <input type="checkbox"/> Leg swelling                         | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Rapid or irregular heart beat      | <input type="checkbox"/> Varicose veins |   |                                       |
| <input type="checkbox"/> Difficulty breathing with exertion |   | <input type="checkbox"/> Difficulty breathing when lying flat |                                       |
| <input type="checkbox"/> Other _____                        |   |   |                                       |

### Respiratory

- |   |  |   |                                    |
|---|--|---|------------------------------------|
| <input type="checkbox"/> Chronic cough                      | <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Painful breathing                    | <input type="checkbox"/> Shortness |
| <input type="checkbox"/> Rapid or irregular heart beat      | <input type="checkbox"/> Varicose veins    |   |                                    |
| <input type="checkbox"/> Difficulty breathing with exertion |  | <input type="checkbox"/> Difficulty breathing when lying flat |                                    |
| <input type="checkbox"/> Other _____                        |  |   |                                    |

### Gastrointestinal

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Abdominal mass | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Black stools    | <input type="checkbox"/> Bloody stools                |
| <input type="checkbox"/> Constipation   | <input type="checkbox"/> Diarrhea       | <input type="checkbox"/> Hemorrhoids     | <input type="checkbox"/> Incontinence of stool or gas |
| <input type="checkbox"/> Indigestion    | <input type="checkbox"/> Jaundice       | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Rectal pain                  |
| <input type="checkbox"/> Other _____    |   |  |   |

### Genitourinary

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Abdominal bleeding  | <input type="checkbox"/> Absence of periods          | <input type="checkbox"/> Blood in urine     | <input type="checkbox"/> DES exposure             |
| <input type="checkbox"/> Fibroids            | <input type="checkbox"/> Frequent bladder infections | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> History of endometriosis |
| <input type="checkbox"/> Incomplete emptying | <input type="checkbox"/> Incontinence of urine       | <input type="checkbox"/> Infertility        | <input type="checkbox"/> Pain with urination      |
| <input type="checkbox"/> Painful intercourse | <input type="checkbox"/> Painful periods             | <input type="checkbox"/> Pelvic pain        | <input type="checkbox"/> Premenstrual syndrome    |
| <input type="checkbox"/> Urgency to urinate  | <input type="checkbox"/> Vaginal discharge           | <input type="checkbox"/> Vaginal dryness    | <input type="checkbox"/> Vaginal itching          |
| <input type="checkbox"/> Other _____         |  |   |   |

### Musculoskeletal

- |  |   |   |                                      |
|--|---|---|--------------------------------------|
| <input type="checkbox"/> Back pain       | <input type="checkbox"/> Joint pain/stiffness | <input type="checkbox"/> Joint swelling | <input type="checkbox"/> Muscle pain |
| <input type="checkbox"/> Muscle weakness |   |   |                                      |
| <input type="checkbox"/> Other _____     |   |   |                                      |

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**Skin**

- |   |  |                                   |  |
|---|--|-----------------------------------|--|
| <input type="checkbox"/> Acne                 | <input type="checkbox"/> Discoloration | <input type="checkbox"/> Dry skin | <input type="checkbox"/> Easy bruising |
| <input type="checkbox"/> Enlarged lymph nodes | <input type="checkbox"/> Itching       | <input type="checkbox"/> Moles    | <input type="checkbox"/> Rash          |
| <input type="checkbox"/> Sores                |  |                                   |  |
| <input type="checkbox"/> Other _____          |  |                                   |  |

**Breasts**

- |                                      |                                      |  |   |
|--------------------------------------|--------------------------------------|--|---|
| <input type="checkbox"/> Breast mass | <input type="checkbox"/> Breast pain | <input type="checkbox"/> Breast swelling | <input type="checkbox"/> Nipple discharge/blood |
| <input type="checkbox"/> Other _____ |                                      |  |   |

**Neurologic**

- |   |                                    |                                    |  |
|---|------------------------------------|------------------------------------|--|
| <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Memory problems |
| <input type="checkbox"/> Numbness           | <input type="checkbox"/> Seizures  | <input type="checkbox"/> Tremor    |  |
| <input type="checkbox"/> Other _____        |                                    |                                    |  |

**Psychiatric**

- |                                      |                                     |  |
|--------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Anxiety     | <input type="checkbox"/> Depression | <input type="checkbox"/> Frequent crying |
| <input type="checkbox"/> Other _____ |                                     |  |

**Endocrine**

- |  |  |   |                                    |
|--|--|---|------------------------------------|
| <input type="checkbox"/> Abnormal hair growth  | <input type="checkbox"/> Abnormal thirst | <input type="checkbox"/> Deepening of voice | <input type="checkbox"/> Hair loss |
| <input type="checkbox"/> Heat/cold intolerance | <input type="checkbox"/> Hot flashes     |   |                                    |
| <input type="checkbox"/> Other _____           |  |   |                                    |