PATIENT INTAKE HISTORY FORM

DATE: _____

First Name:		**MI:**	**Last:**
DOB:	**SSN:**		**Occupation:**
Primary Care Provider:			**Referring Provider:**

CHIEF COMPLAINT

Why are you seeing the doctor today?

MEDICAL HISTORY

Major medical problems:

Surgery:

Date:	**Reason:**
Date:	**Reason:**
Date:	**Reason:**
Date:	**Reason:**

Complication from surgery? ☐ **yes** ☐ **no** **If yes, please describe:**

MEDICATION ALLERGIES: ☐ **NO KNOWN DRUG ALLERGIES**

OTHER ALLERGIES:

Current Medications (include prescription, over-the-counter, herbal and vitamin supplements):

FAMILY HISTORY

Father disease(s):	_____	**If deceased, at what age?**
Mother disease(s):	_____	**If deceased, at what age?**

SOCIAL HISTORY

Habits:

Smoke:	**Number of years:**		**Packs per day:**	**If quit, how long ago?**
Drink:	☐ **never**	☐ **some**	**Average per day:**	**OR per month:**

Exercise:

Type:	**Times per week:**
Type:	**Times per week:**
Type:	**Times per week:**

REVIEW OF SYSTEMS

PLEASE BRIEFLY COMMENT ON ANY YES ANSWER		YES	NO	COMMENT
GENERAL	Change in weight or energy level			
BONES	Broken bones in past			
	Bone or joint pain			
	Swelling or deformity			
RESPIRATORY	Asthma or pneumonia			
	Cough or shortness of breath			
	Tuberculosis			
SKIN	Change in wart or mole			
	Rash			
	Lumps			
Head, Eyes, Ears, Nose, Throat	Glasses or contacts			
	Problems swallowing or hoarseness			
	Headaches or sinus congestion			
NECK	Swollen glands			
	Pain or stiffness			
GI/GU	HEPATITIS A, B or C			
	Stomach problems			
	Bowel Problem, black or bloody stools			
	Urinary problems or blood in urine			
	Prostate problems			
	Kidney disease			
MOOD	Depression or anxiety			
	Sleep disorder			
HEART	Heart attack			
	Chest pain or racing heart			
	Swollen feet, varicose veins or blood clots			
NEUROLOGICAL	Seizures			
	Stroke			
	Balance problems			

Any other health problems or concerns that your doctor should know about.