INTAKE HISTORY

Name:_______________________________________ **Birth Date:**____/____/____ **Today's Date:**____/____/____

Name of Spouse/ Partner_______________________________ **Referred by**:________________________________

REVIEW OF SYSTEMS

Please check (x) if any of the following apply to you now, or in the past

1. **CONSTITUTIONAL**	NOW	PAST
a. Weight Loss	☐	☐
b. Weight Gain	☐	☐
c. Fever	☐	☐
d. Fatigue	☐	☐

2. **EYES**	NOW	PAST
a. Double Vision	☐	☐
b. Spots Before Eyes	☐	☐
c. Vision Changes	☐	☐
d. Glasses/ Contacts	☐	☐

3. **ENT/ MOUTH**	NOW	PAST
a. Ear Aches	☐	☐
b. Ringing in Ears	☐	☐
c. Sinus Problems	☐	☐
d. Sore Throat	☐	☐
e. Mouth Sores	☐	☐
f. Dental Problems	☐	☐

4. **CARDIOVASCULAR**	NOW	PAST
a. Painful Breathing	☐	☐
b. Chest Pain	☐	☐
c. Diff. Breath on Exertion	☐	☐
d. Swelling of legs	☐	☐
e. Palpitations of Heart	☐	☐

5. **RESPIRATORY**	NOW	PAST
a. Wheezing	☐	☐
b. Spitting up Blood	☐	☐
c. Shortness of Breath	☐	☐
d. Cough, Chronic	☐	☐

6. **INTESTINAL**	NOW	PAST
a. Diarrhea, Frequent	☐	☐
b. Bloody Stool	☐	☐
c. Nausea/ Vomiting	☐	☐
d. Constipation	☐	☐

7. **GENITOURINARY**	NOW	PAST
a. Blood in Urine	☐	☐
b. Pain with Urination	☐	☐
c. Urgency	☐	☐
d. Frequency of Urination	☐	☐
e. Incomplete Emptying	☐	☐
f. Stress Incontinence	☐	☐
g. Abnormal Periods	☐	☐
h. Painful Intercourse	☐	☐

8. **MUSCULOSKELETAL**	NOW	PAST
a. Muscle Weakness	☐	☐

9. **SKIN/ BREAST**	NOW	PAST
a. Pain in Breast	☐	☐
b. Discharge	☐	☐
c. Masses	☐	☐
d. Rash	☐	☐
e. Ulcers	☐	☐

10. **NEUROLOGICAL**	NOW	PAST
a. Dizziness	☐	☐
b. Seizures	☐	☐
c. Numbness	☐	☐
d. Trouble Walking	☐	☐

11. **PSYCHIATRIC**	NOW	PAST
a. Depression	☐	☐
b. Crying, Frequent	☐	☐

12. **HEMATOLOGIC/LYMPH**	NOW	PAST
a. Bruises, Frequent	☐	☐
b. Cuts do not stop bleeding	☐	☐
c. Enlarged Lymph Nodes	☐	☐

13. **ALLERGIC/IMMUNE** Please list
a. Allergies ________________
b. Drugs, Other ________________
____

14. **ENDOCRINE**	NOW	PAST
a. Dry Skin	☐	☐
b. Abnormal Thirst	☐	☐
c. Hot Flashes	☐	☐

COMMENTS NEGATIVE ☐

1, 5 PERSONAL PAST MEDICAL HISTORY/ FAMILY MEDICAL HISTORY

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU OR A BLOOD RELATIVE

UNKNOWN / ADOPTED ☐ (Code: M=Mother, F=Father, MF=Maternal Father, MM=Maternal Mother)

MAJOR ILLNESS	YOU	BLOOD RELATIVE		YOU	BLOOD RELATIVE		YOU	BLOOD RELATIVE
1. Asthma	☐	☐	10. Pneumonia	☐	☐	19.Chronic Lung Disease	☐	☐
2. Kidney Infections/ Stone	☐	☐	11. Tuberculosis	☐	☐	20. Venereal Disease	☐	☐
3. Heart Disease/ Murmur	☐	☐	12. Diabetes	☐	☐	20. Thyroid Disease	☐	☐
4. High Blood Pressure	☐	☐	13. Stroke	☐	☐	21. Rheumatic Fever	☐	☐
5. Breast Cancer	☐	☐	14. Colon Cancer	☐	☐	22. Ovarian Cancer	☐	☐
6. Ulcers	☐	☐	15. Depression/ Anxiety	☐	☐	23. Bowel Trouble	☐	☐
7Anemia/ Blood Transfusions	☐	☐	16. Glaucoma	☐	☐	24. Fracture	☐	☐
8. Seizures/Epilepsy	☐	☐	17. Arthritis/ Joint Pain	☐	☐			
9. Hepatitis/ Yellow Jaundice	☐	☐	18. Drinking/ Drug Problem	☐	☐			

COMMENTS NEGATIVE ☐

CERVICAL CANCER RISK FACTORS Please Check (X) Yes or No

Onset of Sexual activity before 16 years old?	YES☐	NO☐	Five or more sexual partners in your lifetime?	YES☐	NO☐
History of HIV?	YES☐	NO☐	History of sexually transmitted disease?	YES☐	NO☐
Prenatal exposure to DES	YES☐	NO☐			
Ever had an abnormal Pap smear?	YES☐	NO☐	When?		
Last Pap Smear Date?					
Medicare Annual					
High Risk	YES ☐	NO☐	Next Pap 1 Year ☐	3 Years ☐	
Results?					

2 PAST OPERATIONS AND HOSPITALIZATIONS **NONE** ☐

Reason	Date	Reason	Date

INJURIES/ ILLNESSES **NONE** ☐

Type	Date	Type	Date

IMMUNIZATIONS **CURRENT** ☐	DATE	**OB / GYN HISTORY**	NUMBER	DATES
Tetanus		Pregnancies		
Flu Shot		Term Births		
Pneumonia		Preterm Births		
TB Skin Test		Miscarriages		
		Abortions		
		Living Children		

3 CURRENT MEDICATIONS NONE ☐

Drug Name	Dosage	Drug Name	Dosage

6 SOCIAL HISTORY

HABITS

Smoking	YES☐	NO☐	Packs per day_____	Years_____
Alcohol	YES☐	NO☐	Drinks per day_____	Drinks per week_____
Drug Use	YES☐	NO☐		
Seat Belt Use	YES☐	NO☐		
Regular Exercise	YES☐	NO☐		

PERSONAL PROFILE

Marital Status Married☐ Single☐ Widowed☐ Divorced☐

Number of People in Household___________

School Completed High School☐ College☐ Graduate Degree☐ Other☐

Current or Most Recent Job_______________

Race__________________________

Completed by: Patient☐ Nurse☐ Physician☐

Signature of Patient____

Date Reviewed by Physician with Patient____

Physician Signature____

ANNUAL REVIEW OF HISTORY

Date Reviewed_____________________Physician Signature______________________________

Date Reviewed_____________________Physician Signature______________________________

Date Reviewed_____________________Physician Signature______________________________

Date Reviewed_____________________Physician Signature______________________________

Date Reviewed_____________________Physician Signature______________________________