HISTORY INTAKE FORM

DATE: _____

PATIENT NAME: _____ Occupation: _____ BIRTHDATE: ____/____/____

Marital Status: M S D W

Operations: AGE: _____

Yes No

Allergies: ____ ____

If Yes what are they_____

_____

Medical History:

If none please initial_____

How Much

Medications:

Smoke Y/N

Alcohol Y/N

Drugs Y/N

Caffeine Y/N

PAST MEDICAL HISTORY Have you ever had the following :(Circle "no" or "yes", leave blank if uncertain)

Pneumonia	Y/N	Hernia	Y/N	Hepatitis	Y/N
Heart Disease	Y/N	Transfusions	Y/N	Ulcer	Y/N
Arthritis	Y/N	Back Trouble	Y/N	Kidney Disease	Y/N
Anemia	Y/N	H. Blood Pressure	Y/N	Thyroid Disease	Y/N
Tuberculosis	Y/N	Asthma	Y/N	Bleeding Tendency	Y/N
Diabetes	Y/N	AIDS or HIV +	Y/N	Other:	Y/N
Cancer	Y/N	Bronchitis	Y/N		
Glaucoma	Y/N	Stroke	Y/N		

FAMILY HISTORY

Cancer	Y/N	Bleeding Tendency	Y/N	Kidney Disease	Y/N
Tuberculosis	Y/N	Asthma	Y/N	Gout	Y/N
Diabetes	Y/N	C. Lung Disease	Y/N	Other:	
Heart Disease	Y/N	Drug/Alcohol		Y/N	
Anemia	Y/N	Ulcer	Y/N		

REVIEW OF SYSTEMS MUST FILL IN EACH BODY SYSTEM with Yes or No for Comprehensive ROS (One from each block)

Constitutional:

Wt. Change Y/N

Change Appetite Y/N

Weight: gain or loss

Fever Y/N

Eyes:

Glasses/Contacts Y/N

Ears, Nose, Throat:

Hearing Loss Y/N

Freq. nose Bleeds Y/N

Sinus problems Y/N

Cardiac/Vascular:

Palpitations Y/N

Heart Flutter Y/N

Chest Pain Y/N

Women Only:

Preg: AB LC

LMP: _____

Birth Control: Y/N

Respiratory:

Shortness Breath Y/N

Wheezing Y/N

Gastrointestinal:

Heartburn Y/N

Abd. Cramping Y/N

Chronic Diarrhea Y/N

Constipation Y/N

Rectal Bleeding Y/N

Hemorrhoids Y/N

Genitourinary:

Freq. Day Urination Y/N

Painful Urination Y/N

Leakage of Urine Y/N

Blood in Urine Y/N

Freq. pm Urination Y/N

Integumentary (skin, breasts):

Skin Rash Y/N

Breast Lump Y/N

Nipple Discharge Y/N

Neurological:

Poor Coordination Y/N

Seizures Y/N

Endocrinology:

Increased Thirst Y/N

Hair Loss Y/N

Musculoskeletal:

Backaches Y/N

Broken Bones Y/N

Psychological:

Depression Y/N

Memory Loss Y/N

Reason for todays visit: _____

_____

Have you had any of the following in the last 12 months:

Colonoscopy: Y/N Date: _____

Flu Shot: Y/N Date: _____

Mammogram: Y/N Date:_____

ROS and Family, Social and Past Medical Doctor reviewed history with patient at visit.

Patient Signature Date

Physician Signature Date