New Patient Intake Form

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Cell phone: _____ Home phone: _____

May we leave messages at the above numbers? ☐ Yes ☐ No

Social Security#: _____ Marital Status: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Occupation: _____ Employer: _____

Insurance: _____ Policy#: _____ Group#: _____

Subscriber name: _____ Subscriber date of birth: _____

Relation to patient: _____ Effective Date: _____

Subscriber Employer: _____

Subscriber Employer Address: _____

Secondary Insurance: _____ Policy#: _____ Group#: _____

How did you find out about us? ☐ Mailer ☐ Facebook ☐ Friend ☐ Radio ☐ Internet ☐ Drive by ☐ Seminar ☐ Other

What prompted you to choose us for your healthcare needs? _____

_____

Primary Care Provider: _____ Home phone: _____

Other Physicians Involved in Care: _____

Winter Visitor: ☐ Yes ☐ No Home State: _____

Medical History

Reason for Visit? _____

Is today's visit due to a car accident or work injury? ☐ No ☐ Yes

Past Medical History: (Check all that apply)

☐ Acid Reflux (GERD)	☐ Coronary Artery Disease	☐ Insomnia	☐ Seasonal Allergies
☐ Anxiety	☐ Depression	☐ Irritable Bowel Syndrome	☐ STD
☐ Arthritis	☐ Diabetes Last A1C: _____	☐ Kidney Disease	☐ Stroke
☐ Asthma	☐ Epilepsy/Seizures	☐ Liver Disease	☐ Thyroid Disease
☐ Atrial fibrillation	☐ Heart Attack	☐ Lung Disease	☐ Urinary Tract Infections
☐ Blood Clots	☐ Hiatal hernia	☐ Memory Problems	☐ Other, not listed:
☐ Cancer	☐ High Cholesterol	☐ Parkinson's	_____
☐ Constipation	☐ Hypertension	☐ Prostate Enlargement	_____

Past Surgical History:

☐ Appendix	☐ Heart Surgery	☐ Hysterectomy	☐ Prostate
☐ Back Surgery	☐ Hernia	☐ Joint Replacement	☐ Skin Cancer
☐ Gall Bladder	☐ Hip Surgery	☐ Knee Surgery	☐ Tonsillectomy

☐ Other, not listed: _____

Imaging (XRay's, MRI's) in the last 3 months. ☐ N ☐ Y- Name of facility/location _____

Broken Bones: _____

Surgical Devices/ Implants: _____

Hand Dominance: ☐ Left ☐ Right **Assistive Devices:** _____

Family History:

☐ Cancer	☐ Unexplained death before age 50
☐ Diabetes	☐ Arthritis
☐ Heart Disease	☐ Other, not listed: _____

Social History:

☐ Live alone ☐ Live with others, relationship _____

Exercise: ☐ No ☐ Yes, type/ frequency

Tobacco Use: ☐ Never ☐ Past Use, Quit date: _____ ☐ Yes, Amount/Day _____

Alcohol Use: ☐ No ☐ Yes, Amount _____ Caffeine Use: ☐ No ☐ Yes, Amount _____

Drug Use: ☐ No ☐ Yes Type, Frequency _____

Medications & Review of Systems

Current list of medications

Please list ALL medications. Include name, dosage, frequency, over the counter medications, vitamins and supplements

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medication Allergies: _____

Review of Systems - please check (x) if you have had any of the following in the last 12 months

General
☐ Chills
☐ Fever
☐ Fatigue
☐ Weakness
☐ Weight changes
☐ Sleep changes
☐ Falls
☐ Other:

Allergies
☐ Food
☐ Seasonal
☐ Environmental
☐ Skin
☐ Other:

Cardiovascular
☐ Chest pain
☐ Palpitations
☐ Irregular heartbeat
☐ Heart murmur
☐ Leg swelling
☐ Fainting
☐ Varicose

Respiratory
☐ Cough
☐ Shortness of breath
☐ Wheezing
☐ Difficulty breathing
☐ Snoring
☐ Sleep Apnea
☐ CPAP
☐ Other:

Eyes, Ears, Nose, Throat
☐ Blurred vision
☐ Eye redness
☐ Eye injury
☐ Itchy eyes
☐ Ear pain
☐ Hearing loss
☐ Ringing in the ears
☐ Runny nose
☐ Nosebleeds
☐ Congestion
☐ Snoring
☐ Hoarseness
☐ Sore throat
☐ Difficulty swallowing
☐ Mouth ulcers, sores
☐ Other:

Hematologic
☐ Abnormal bruising
☐ Abnormal bleeding
☐ Swollen glands, lymph nodes
☐ Anemia
☐ Skin discoloration
☐ Other:

Mental Health
☐ Anxiety
☐ Depression
☐ Insomnia
☐ Sense of danger
☐ Eating disorder
☐ Frightening visions or sounds
☐ Loneliness
☐ Suicidal thoughts
☐ Other:

Gastrointestinal
☐ Abdominal pain
☐ Bloating
☐ Gas
☐ Constipation
☐ Frequent hiccups
☐ Bloody stool
☐ Diarrhea
☐ Vomiting
☐ Ulcers
☐ Heartburn
☐ Painful swallowing
☐ Hemorrhoids
☐ Other:

Musculoskeletal
☐ Osteoarthritis
☐ Rheumatoid arthritis
☐ Back pain
☐ Neck pain
☐ Shoulder pain
☐ Knee pain
☐ Hip pain
☐ Gout
☐ Muscle pain
☐ Pain with walking
☐ Muscle weakness
☐ Other:

Genitourinary
☐ Blood in urine
☐ Painful urination
☐ Frequent urination
☐ Kidney stones
☐ Urinary incontinence
☐ Discharge or odor
☐ Sexually transmitted infection
☐ Other:

Neurologic
☐ Headaches
☐ Migraine
☐ Dizziness
☐ Memory loss
☐ Seizures
☐ Vision changes
☐ Tingling/numbness
☐ Excessive sleeping
☐ Difficulty with concentration
☐ Difficulty with coordination
☐ Other:

Skin
☐ Abnormal pigmentation
☐ Acne
☐ Rashes
☐ Wounds
☐ Excessive sweating
☐ Hives, rash
☐ Eczema
☐ Poor wound healing
☐ Dryness, itching
☐ Other:

Men only:
☐ Testicular pain or swelling
☐ Frequent night urination
☐ Lack of sexual drive
☐ Difficulty with erection
☐ Difficulty with ejaculation
☐ PSA (Date: _____)

Women Only:
☐ Irregular periods
☐ Lack of sexual drive
☐ Pain during intercourse
☐ Painful periods
☐ Menopausal
☐ Hormone replacement

Age period started _____
# of days it lasts _____
# of pregnancies _____
# of miscarriages _____
First day of last period _____
Provider Reviewed _____