Confidential Patient Intake

Today's Date: ___/____/_______

How did you hear about us? Family _______________ Friend / Co-worker __________________
Close to home/work Dr. _____________ Hospital Insurance Plan Website / Internet

Personal Information

Title: Mr. Ms. Mrs. Other __________

Last:__________________________ First:___________________________ Middle: ____________________________

Birth Date: ____ /____/_______ Age:______ Sex: Male / Female SSN: ______________________

Marital Status: Single Married Widowed Divorced Separated

Address: ____Apt # ______

City: __________________ State: ______ Zip: _________ Country: __________________

Home Phone: (_______) _______-_________ ext ______

Cell Phone: (_______) _______-_________ ext ______ Driver's License #: ______________________

Emergency contact: ___________________ Phone#: ________________ Relationship to patient: ____________________

Insurance:______________________ Policy #:_______________________ Group #_________________________

Guarantor Name: ________________________ Relationship to insured: ________________________

Current Health Condition

Chief Complaint (Why you are here today?):________________

When did this Condition BEGIN? _____/_______/_________

Has it ever occurred before? Yes No. When? _____________

Duration of symptoms: ____

____

REVIEW OF SYSTEMS - Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

Constitutional: I DENY having or have had any of the symptoms or problems listed below.

chills	fatigue	weight loss
fever	night sweats	

Patient Name: ______________________________ Date:______________

Eyes/Vision: **I DENY having any of the symptoms or problems listed below.**

change in vision	**photophobia**
glaucoma	**tearing**
cataracts	**itching**

Ears, Nose and Throat: **I DENY having any of the symptoms or problems listed below.**

bleeding	**dizziness**	**hearing loss**	**nosebleeds**	**sinus infection**
dentures	**headaches**	**history of head injury**	**runny nose**	**sore throat**

Respiration: **I DENY having any of the symptoms or problems listed below.**

asthma	**shortness of breath**
cough	**wheezing**

Cardiovascular: **I DENY having any of the symptoms or problems listed below.**

angina (chest pain or discomfort)	**high blood pressure**	**shortness of breath**
chest pain	**low blood pressure**	**swelling of legs**
claudication (leg pain/ache)	**orthopnea** (difficulty breathing lying down)	**ulcers**
heart murmur	**palpitations**	**varicose veins**

Gastrointestinal: **I DENY having any of the symptoms or problems listed below.**

abdominal pain	**heartburn**
constipation	**indigestion**
diarrhea	**nausea**
difficulty swallowing	**vomiting**

Endocrine: **I DENY having any of the symptoms or problems listed below.**

DIABETES
Pain with urinating
Thyroid condition

Skin: **I DENY having any of the symptoms or problems listed below.**

changes in skin color	**history of skin disorders**	**paresthesias**	**skin ulcers**
hair growth	**hives**	**rash**	**varicosities**
hives	**itching**	**skin lesions**	

Nervous System: **I DENY having any of the symptoms or problems listed below.**

dizziness	**limb weakness**	**seizures**	**stroke**	**unsteady gait**
facial weakness	**numbness**	**slurred speech**	**tremor**	

Patient Name: ___________________________________ Date:________________

Allergy: **I DENY having any of the symptoms or problems listed below.**

anaphalaxis **itching** **rash** **sneezing**

Hematologic: **I DENY having any of the symptoms or problems listed below.**

anemia
bleeding
blood clotting
blood transfusion
bruising easily
fatigue
lymph node swelling

PAST HEALTH HISTORY – **Fill out carefully as these problems can affect your overall course of care.**

Current Medication (s): **List ANY/ALL medications you are CURRENTLY taking OR PROVIDE OWN LIST**

Medication	Dosage	For What Condition?

Adult Illness(es): **MARK all CURRENT conditions.**

anemia
arthritis
asthma
cancer
cerebral palsy
CRPS (RSD)
CVA (stroke)
cystic kidney disease
diabetes
eczema
emphysema
fibromyalgia
heart disease
hepatitis
hypertension
liver disease
lung disease
lupus erythema
multiple sclerosis
parkinson's disease
psoriasis
rheumatoid arthritis
seizure disorder
smoking
thyroid problems
other:

Surgery (ies): **MARK all previous surgeries**

angioplasty
cardiac catheterization
coronary artery bypass
defibrilator
dental surgery
joint reconstruction
joint replacement
knee repair
laminectomy
pacemaker insertion
rotator cuff
spinal fusion
other:

Patient Name: ___________________________________ Date:________________

Family History:	**Mark all that apply below. List any specific conditions past or present after has/had:**			
general family	**alive**	**deceased**	**no significant disease**	**has/had:**________________________________
father	**alive**	**deceased**	**no significant disease**	**has/had:**________________________________
mother	**alive**	**deceased**	**no significant disease**	**has/had:**________________________________
son (s)	**alive**	**deceased**	**no significant disease**	**has/had:**________________________________
daughter(s)	**alive**	**deceased**	**no significant disease**	**has/had:** ________________________________
brother(s)	**alive**	**deceased**	**no significant disease**	**has/had:** ________________________________
sister(s)	**alive**	**deceased**	**no significant disease**	**has/had:**________________________________

Social History

Alcohol: Never Social Consumption only

Education (please mark the highest level completed):
Did Not Finish High School High School Diploma Assoc/Technical Degree
College Degree Graduate Degree Doctorate Other: ____________________

Drugs: Deny any illegal drug use Deny use of IV drugs Have not used drugs since _________ Have used drugs for ________
Tobacco: Deny Tobacco Use Do not smoke cigars, cigarettes or pipe Live with a smoker Quit smoking
Smoke; # ________ per Day Week Month Chew; #_________cans per Day Week Year

---

I acknowledge that I have received the Clinic's Notice of Privacy Practices for protected health information.

Patient Print Name: ____ **Date:** ______________

Patient's Signature: ____ **Date:** ______________