History Intake Form

Patient Name:______________________________________________
Date of Birth:________________
Age:_______ Race:__________________ Gender: M F City _______________________________
Who Referred:___________________________________________________________________________
Purpose of your visit today___________________________________________________________________

Review of Systems
Do you have now or have you had in the past (please circle):

- Weight change yes/no
- Swollen feet/ankles yes/no
- Seizures yes/no
- Dry eyes yes/no
- Skin rash yes/no
- Neck Pain yes/no
- Chronic cough yes/no
- Chronic diarrhea yes/no
- Swollen lymph nodes yes/no
- Chest pain yes/no
- Jaundice yes/no
- Back Pain yes/no
- Anesthesia problems yes/no
- Depression/anxiety yes/no
- Rapid heartbeat yes/no
- Joint/muscle pain yes/no
- Easy bleeding/bruising yes/no
- Joint problems yes/no

Please answer all of the questions as accurately as possible. If you do not understand the question, please ask for assistance.

Past Medical History:
Have you ever had the following (please circle):

- Heart attack yes/no
- High blood pressure yes/no
- Irregular heartbeat yes/no
- Diabetes yes/no
- Stroke yes/no
- Kidney disease yes/no
- Clotting Problems yes/no
- Osteoporosis yes/no
- Post Menopausal yes/no
- Cancer yes/no
- Asthma yes/no
- Stomach ulcer yes/no
- Arthritis yes/no
- Glaucoma yes/no
- Depression/anxiety yes/no
- Heart Disease yes/no
- RA/Lupus yes/no
- COPD yes/no
- Thyroid disease yes/no
- Anemia yes/no
- AIDS/HIV+ yes/no
- Tuberculosis yes/no
- Mitral valve prolapse yes/no
- Hepatitis yes/no
- Chronic Infection yes/no
- High Cholesterol yes/no
- Heart Failure yes/no

Please list all other medical problems/illnesses (any reason for which you are seeing or have seen a doctor):

__________________________________________
__________________________________________
__________________________________________

Do you take antibiotics before dental work? yes/no → → If yes, what antibiotic? __________________________
Name:_____________________________________

**Past Surgical History:**
Please list any previous surgeries and date:

<table>
<thead>
<tr>
<th>Date</th>
<th>Surgery</th>
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**Medication List:**
Please list all medications you are taking, including nonprescription drugs, vitamins and herbals (use separate sheet if necessary).

<table>
<thead>
<tr>
<th>Medication name</th>
<th>Dose</th>
<th>How often</th>
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**Allergies or Reactions to Medications**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Type of Reaction</th>
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**Family History**
Has any blood relative ever had the following (please circle):

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes/No</th>
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<tbody>
<tr>
<td>Breast cancer</td>
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<tr>
<td>High blood pressure</td>
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<td>Kidney disease</td>
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<td>Bleeding Problems</td>
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<td>Melanoma</td>
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<td>Heart Disease</td>
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<tr>
<td>Depression/anxiety</td>
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<tr>
<td>Clotting problems</td>
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<tr>
<td>Stroke</td>
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<tr>
<td>Diabetes</td>
<td></td>
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<tr>
<td>Anesthesia problems</td>
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<tr>
<td>Skin Cancer</td>
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</table>
History Intake Form (page 3)

Name: ______________________________

Social History:
Your height: ________ Your weight: ________ Race: _______________________________________

E-mail address so we can send you our Quarterly newsletter?: ________________________________

Occupation: __________________________________________________________________________

Married, single, divorced, widowed (Circle one)

How many Children & ages: ______________________________________________________________

Do you consume alcohol? yes/no → → If yes, type & amount per week: _________________________

Do you smoke? Yes/no Cigars or Cigarettes (Please Circle)?

If yes, amount per day: _________________________________________________________________

Do you chew tobacco? yes/no
Do you ever smoke marijuana (pot)? yes/no
Have you ever used “street drugs”? yes/no Type: _________________________________________

Women Only:

Age period began: __________ Do you do regular breast self-examinations? yes/no
Date of last mammogram: __________ Have you ever had an abnormal mammogram? yes/no
Number of pregnancies: __________ Have you ever had a breast lump? yes/no
Did you breast feed? yes/no Have you ever had discharge from the nipple? yes/no

I verify that the above information is true and accurate to the best of my knowledge.

_________________________________________  ______________________________________
Signature of patient (or parent if patient is a minor)       Date

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