HISTORY INTAKE FORM

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PATIENT INFORMATION

NAME *LAST*	*FIRST*	*MIDDLE*	BIRTH DATE	AGE	HEIGHT	WEIGHT

REASON OF VISIT: _____ PRIMARY CARE DOCTOR: _____

SMOKING (TYPE & AMOUNT PER DAY): _____ IF FORMER SMOKER, DATE QUIT: _____

ALCOHOL CONSUMPTION (TYPE AND AMOUNT PER WEEK): _____

DRUG ALLERGIES: _____

_____

LIST PREVIOUS SURGERIES OR MAJOR ILLNESSES AND DATES: _____

_____

LIST ANY MEDICATIONS YOU ARE TAKING, INCLUDING NON-PRESCRIPTION DRUGS, VITAMINS, AND HERBALS: _____

_____

_____

PATIENT MEDICAL HISTORY

Have you ever had the following:

Depression……	❑ YES	❑ NO	Cancer……	❑ YES	❑ NO	Stomach Ulcer……	❑ YES	❑ NO
Arthritis……	❑ YES	❑ NO	Glaucoma……..…	❑ YES	❑ NO	Kidney Disease……..	❑ YES	❑ NO
Rheumatic Fever….	❑ YES	❑ NO	Asthma……	❑ YES	❑ NO	Thyroid Disease……..	❑ YES	❑ NO
Anemia……..	❑ YES	❑ NO	AIDS or HIV+…….....	❑ YES	❑ NO	Bleeding Tendency…….	❑ YES	❑ NO
Tuberculosis…….	❑ YES	❑ NO	Stroke…….....	❑ YES	❑ NO	Mitral Valve Prolapse…..	❑ YES	❑ NO
Diabetes……	❑ YES	❑ NO	Hepatitis……..…	❑ YES	❑ NO	High Blood Pressure….	❑ YES	❑ NO

REVIEW OF SYMPTOMS

Do you have now or have you had within the past year:

Weight Change…...	❑ YES	❑ NO	Swollen feet / ankles..	❑ YES	❑ NO	Easily fatigued…….....	❑ YES	❑ NO
Dry eyes……...	❑ YES	❑ NO	Skin rash……...	❑ YES	❑ NO	Seizures……...	❑ YES	❑ NO
Chronic cough…….	❑ YES	❑ NO	Chronic diarrhea…….	❑ YES	❑ NO	Joint or muscle pain…..	❑ YES	❑ NO
Chest pain……...	❑ YES	❑ NO	Jaundice……	❑ YES	❑ NO	Swollen lymph nodes….	❑ YES	❑ NO
Rapid heart beat….	❑ YES	❑ NO	Depression……	❑ YES	❑ NO	Easy bleeding……..	❑ YES	❑ NO
Nausea / vomiting….	❑ YES	❑ NO	Difficulty breathing…..	❑ YES	❑ NO	Easy bruising……..	❑ YES	❑ NO
						Shortness of breath…..	❑ YES	❑ NO

FAMILY MEDICAL HISTORY

Has any blood relative ever had the following:

Breast Cancer……..	❑ YES	❑ NO	High Blood Pressure..	❑ YES	❑ NO	Kidney Disease……...	❑ YES	❑ NO
Melanoma……	❑ YES	❑ NO	Heart Disease…….	❑ YES	❑ NO	Depression……..	❑ YES	❑ NO
Stroke……	❑ YES	❑ NO		❑ YES	❑ NO			

WOMEN ONLY

Age period began _____		Did you breastfeed..……..	❑ YES ❑ NO
Date of last mammogram _____		Breast lump or discharge……....	❑ YES ❑ NO
Number of pregnancies _____		Do you do regular self breast exams...	❑ YES ❑ NO

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

_____ _____

Signature of patient or parent if minor Date