New Patient Intake

Patient Name: ____________________ Date of Birth: ____________ Today's Date: ____________________

Please provide the following medical information to the best of your ability:

What problems are you here for today?:

____

Please list any current medications (amounts and times taken per day), Include aspirin, antacids, vitamins, hormone replacement, birth control, herbal supplements, OTC medications including sinus/allergy/weight loss.

____

List any allergies or sensitivities to medications:

____

MEDICAL HISTORY

Please check the appropriate box to indicate if you or anyone n your family have any of the following:

	You	*Family*
Anemia	☐	☐
Anesthetic Complications	☐	☐
Blood Clotting Disorder	☐	☐
Brain Injury	☐	☐
Cancer	☐	☐
Carpal Tunnel	☐	☐
Cerebral Palsy	☐	☐
Depression	☐	☐
Type I Diabetes	☐	☐
Type II Diabetes	☐	☐
Deep Vein Thrombosis (DVT)	☐	☐
Gout	☐	☐
Hepatitis	☐	☐
Hypertension (High Blood	☐	☐
Pressure)	☐	☐
Immune Deficiency	☐	☐
Kidney Disease	☐	☐

	You	*Family*
Liver Disease	☐	☐
Mood Disorder	☐	☐
MRSA (Multi-Drug Resistant	☐	☐
Staph)	☐	☐
Myocardial Infarction (Heart	☐	☐
Attack)	☐	☐
Osteoarthritis	☐	☐
Osteoporosis	☐	☐
Peripheral Neuropathy	☐	☐
Rheumatoid Arthritis	☐	☐
Sleep Apnea	☐	☐
Spinal Cord Injury	☐	☐
Staph Infection	☐	☐
Stroke	☐	☐
Thyroid Disease	☐	☐
Ulcers	☐	☐
Vascular Disease	☐	☐

SOCIAL HISTORY

	Yes	*Not Currently*	*No*	Please list details below:
Do you use tobacco?	☐	☐	☐	Type: _________ PPD: ________ Years: _______ When did you quit? ______________________
Do you drink alcohol?	☐	☐	☐	Type: ______________ Drinks per week: _____
Do you use recreational drugs?	☐	☐	☐	Type: ______________ Use per week: _______

What is your occupation? ____

Marital Status: ☐ Single ☐ Married ☐ Legally Separated ☐ Divorced ☐ Widowed ☐ Significant Other

REVIEW OF SYSTEMS

Please check the Yes or No box to indicate whether you presently have any of the following symptoms:

CONSTITUTION	Yes	No		Yes	No
Fever	☐	☐	Malaise	☐	☐
Chills	☐	☐	Sweating	☐	☐
Weight Loss	☐	☐			

SKIN	Yes	No		Yes	No
Rash	☐	☐	Itching	☐	☐

HEAD, EARS, NOSE, THROAT	Yes	No		Yes	No
Hearing Loss	☐	☐	Congestion	☐	☐
Ringing in ear	☐	☐	Sinus Pain	☐	☐
Ear pain	☐	☐	High Pitch Wheezing	☐	☐
Ear discharge	☐	☐	Sore Throat	☐	☐
Nose Bleed	☐	☐			

EYES	Yes	No		Yes	No
Blurred vision	☐	☐	Eye pain	☐	☐
Double vision	☐	☐	Eye discharge	☐	☐
Sensitivity to light	☐	☐	Eye redness	☐	☐

CARDIOVASCULAR	Yes	No		Yes	No
Chest pain	☐	☐	Water retention in legs	☐	☐
Palpitations	☐	☐			
Orthopnea (short of breath when lying flat)	☐	☐	PND (severe shortness of breath & coughing at night	☐	☐
Claudication (cramping pain in leg induced by exercise)	☐	☐			

RESPIRATORY	Yes	No		Yes	No
Cough	☐	☐	Short of breath	☐	☐
Coughing up blood	☐	☐	Wheezing	☐	☐
Sputum production	☐	☐			

GASTRO INTESTINAL	Yes	No		Yes	No
Heartburn	☐	☐	Diarrhea	☐	☐
Nausea	☐	☐	Constipation	☐	☐
Vomiting	☐	☐	Blood in stool	☐	☐
Abdominal pain	☐	☐	Melena (dark stool)	☐	☐

GENITO URINARY	Yes	No		Yes	No
Painful urination	☐	☐	Blood in urine	☐	☐
Urgency	☐	☐	Kidney pain	☐	☐
Frequency	☐	☐			

MUSCULOSKELETAL	Yes	No		Yes	No
Muscle pain	☐	☐	Joint pain	☐	☐
Neck pain	☐	☐	Falls	☐	☐
Back pain	☐	☐			

ENDOCRINE/HEMA/ALLERGY	Yes	No		Yes	No
Easy bruising/bleeding	☐	☐	Excessive thirst	☐	☐
Environmental allergies	☐	☐			

NEUROLOGICAL	Yes	No		Yes	No
Dizziness	☐	☐	Speech change	☐	☐
Headache	☐	☐	Focal weakness	☐	☐
Tingling	☐	☐	Weakness	☐	☐
Tremor	☐	☐	Seizures	☐	☐
Numbness			Loss of consciousness		

PSYCHIATRIC	Yes	No		Yes	No
Depression	☐	☐	Nervous/anxious	☐	☐
Suicidal ideas	☐	☐	Insomnia	☐	☐
Substance abuse	☐	☐	Memory loss	☐	☐
Hallucinations	☐	☐			