

PATIENT INTAKE HISTORY

Patient Name	Date of Birth	Date
Address		
City:	State/Zip	
Home Telephone :	Work Telephone:	
Cellular Telephone:		
Employer:		
Insurance Company	Policy #	Group #
Insurance Co Telephone	Guarantor Name	
Guarantor Date of Birth	Guarantor SS#	
Name of Spouse/Partner	Emergency Contact Name	
Referred By:	Relationship	
How did you hear about us?	Home Telephone	Work Telephone
Please describe your current medical problem, including where it is, how severe it is and how long it has lasted.		

If you are uncomfortable answering any questions, please leave them blank, you can discuss them with your doctor or nurse

Gynecologic History

	Physician's Notes
Last Normal Menstrual period (First Day): / /	
Age Period began:	
Length of periods (Number of days bleeding):	
Number of days between periods:	
Any recent changes in periods:	
Are you currently sexually active?	
Have you ever had sex?	
Number of sexual partners (Lifetime):	
Sexual partners are <input type="checkbox"/> men <input type="checkbox"/> women <input type="checkbox"/> both	
Present method of birth control?	
Have you ever used an intrauterine device (IUD) or birth control pills?	
If yes, for how long?	
When was your last Pap Test?	
What was the result?	
Have you ever had an abnormal pap test?	
Do you do breast self-examinations?	
Have you been exposed to Diethylstilbestrol (DES)?	

PATIENT INTAKE HISTORY (Continued)

Patient Name _____ Date of Birth _____ Date _____

Obstetric History

Pregnancies		Number	Abortions		Number	Miscarriages		Number
Premature Births (<37 wks)			Live Births			Living children		
No.	Date of Birth	Weight at Birth	Baby's Sex	Wks Pregnant	Type of Delivery (Vaginal, cesarean, etc.)		Physician's Notes	
1.								
2.								
3.								
4.								
5.								
Any pregnancy complications?								
<input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension/High Blood Pressure <input type="checkbox"/> Pre-eclampsia/Toxemia <input type="checkbox"/> Other								
Any history of depression before or after pregnancy? <input type="checkbox"/> No <input type="checkbox"/> Yes, How treated								

Current Medications

(Including hormones, vitamins, herbs, nonprescription medications)

Drug Name	Dosage	Who Prescribed	Drug Name	Dosage	Who Prescribed

Family History

Mother: Living		Deceased-Cause:		Age:		Father: Living		Deceased-Cause:		Age:	
Siblings: # Living		# Deceased-Cause:		Ages:		Children: # Living		# Deceased-Cause:		Ages:	
Illness	Yes	Which Relative(s) and age of onset				Physician's Notes					
Diabetes	<input type="checkbox"/>										
Stroke	<input type="checkbox"/>										
Heart Disease	<input type="checkbox"/>										
Blood Clots in lungs or legs	<input type="checkbox"/>										
High blood pressure	<input type="checkbox"/>										
High cholesterol	<input type="checkbox"/>										
Osteoporosis (weak bones)	<input type="checkbox"/>										
Hepatitis	<input type="checkbox"/>										
HIV/AIDS	<input type="checkbox"/>										
Tuberculosis	<input type="checkbox"/>										
Birth Defects	<input type="checkbox"/>										
Alcohol or drug problems	<input type="checkbox"/>										
Breast cancer	<input type="checkbox"/>										
Colon cancer	<input type="checkbox"/>										
Ovarian cancer	<input type="checkbox"/>										
Uterine cancer	<input type="checkbox"/>										
Mental illness/depression	<input type="checkbox"/>										
Alzheimer's disease	<input type="checkbox"/>										
Other	<input type="checkbox"/>										

Patient Name _____

Birthday _____

ID No: _____

Date _____

Social History

	Yes	No	Physician's Notes
Ever Smoked? Current Smoking: Packs per day: _____ Years: _____	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol Drinks per day: ____ Drinks per week: ____ Types of Drink: _____	<input type="checkbox"/>	<input type="checkbox"/>	
Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	
Seat Belt Use	<input type="checkbox"/>	<input type="checkbox"/>	
Regular Exercise: How long and how often?	<input type="checkbox"/>	<input type="checkbox"/>	
Dairy Product intake and/or Calcium supplements: Daily Intake: _____	<input type="checkbox"/>	<input type="checkbox"/>	
Health hazards at home or work?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you been sexually abused, threatened, or hurt my anyone?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have an advance directive (living will)?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you an organ donor?	<input type="checkbox"/>	<input type="checkbox"/>	

Personal Profile

Past Medical History and Review of Systems Check any or all that apply to you whether you are experiencing now or have ever

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Swollen Ankles	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Nausea	<input type="checkbox"/> Colitis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Persistent Cough	<input type="checkbox"/> Lightheaded	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> T.B.	<input type="checkbox"/> Constipation	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Depression
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Asthma	<input type="checkbox"/> Abdominal discomfort	<input type="checkbox"/> Blood in Stool	<input type="checkbox"/> Anemia
<input type="checkbox"/> Headache	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Gall Bladder disease	<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Change in Bowel Habits
<input type="checkbox"/> Unexplained wt gain	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Hepatitis or Jaundice	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Drug Abuse
<input type="checkbox"/> Blood disorders	<input type="checkbox"/> Difficulty urinating	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Skin Diseases	<input type="checkbox"/> Low Back Problems
<input type="checkbox"/> Other _____				

When was your last: Pap Smear _____ Cholesterol check _____
 Mammogram _____ Colon Cancer Test _____
 Breast Exam _____ Prostate exam _____
 Physical _____

Hospitalization/Surgeries

None

Immunizations: (Check all that apply and date)

Hepatitis B _____ Tetanus _____ Other _____

Pnevovax _____ Other _____

Influenza _____

Form completed by: Patient Office Nurse Physician Other

Signature of Patient _____

Date Reviewed by Physician with Patient: / / Physician Signature _____

Annual Review of History

Date reviewed: / / Physician Signature _____

Date reviewed: / / Physician Signature _____

Date reviewed: / / Physician Signature _____

Date reviewed: / / Physician Signature _____

Date reviewed: / / Physician Signature _____

- | | | | | |
|----------------------------------------------|-----------------------------------------------|------------------------------------------------|------------------------------------------|-------------------------------------------------|
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| <input type="checkbox"/> Other _____ | | | | |