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PATIENT INTAKE FORM

Name_____ Age____ Birth Date_____
Address_____ City_____ State___ Zip_____
Home phone_____ Work phone_____ Sex F M
Emergency contact_____ Phone _____

INSURANCE INFORMATION (if applicable)
Name of insured_____ Insured ID _____
Employer_____
Insurance company_____ Group # _____

Please list, in order of importance, your most important health problems:

1) _____
2) _____
3) _____
4) _____
5) _____

YOUR HEALTH HISTORY (Please circle relevant areas):

Alcoholism	Diabetes	Liver disorders
Allergies	Gout	Psychological disorders
Anemia	Heart disorders	Skin disorders
Arthritis	Herpes genitalis	Stroke
Asthma	Hypertension	Thyroid disorders
Cancer	Hypoglycemia	Tuberculosis
Colitis	Injury (serious)	Venereal disease

Other:

_____
_____
_____

HOSPITALIZATIONS (including dates and type of illness/operation):

_____
_____

Known ALLERGIES (to medications, foods, pollens, etc.):

_____

continued →

Current MEDICATIONS and SUPPLEMENTS (include prescription and non-prescription items, herbs, vitamins, minerals, etc.): _____

_____

_____

DIET and HEALTH HABITS:

Number of meals per day:

List foods excluded from your diet _____

Past 24 hour food intake:

Breakfast:

Lunch:

Dinner:

Snacks:

How many glasses of plain water do you drink per day? _____

List 5 foods most frequently eaten: _____

YES NO Satisfied with your diet as it is now?

YES NO Drink alcohol? If yes, amount per week _____

YES NO Drink coffee or soft drinks? If yes, how much _____

YES NO Smoke cigarettes? If yes, how many per day _____

Exercise routine (describe type and frequency): _____

_____

FAMILY HISTORY (circle if yes):

Alcoholism	Gout	Sickle cell anemia
Anemia	Hay fever	Skin disorders
Asthma	Heart disease	Stroke
Hepatitis	High blood pressure	Thyroid disorders
Cancer	Hypoglycemia	Tuberculosis
Diabetes	Mental illness	Veneral disease
Glaucoma	Seizures	Allergies

Other significant family health problems? _____

_____

WOMEN ONLY:

Pregnancies _____ Births _____ Miscarriage/Abortion _____

Age at first menses _____ Cycles regular? _____

Duration of menses _____ Length of cycle _____

Date of last menses _____ Date of last PAP _____

Breast lumps?_____ Do you practice birth control? YES NO

If yes, what type and for how long? _____

Please wear your seatbelt. Thank you!

(Dr's notes below)

appetite fever/chills sweat fatigue weakness sleep cravings weight sensory

Skin/Hair HEENT Cardiac Resp GI GU MuscSkel NeuroPsych Trauma Hx