PATIENT INTAKE: required every 3 years & per new problem

ACCOUNT# _____________ **APPT DATE:** _________________________ **TIME:** ____________ **PHYSICIAN:** ______________

Name of Physician who referred you here for this problem: ________________________________ **(M.D. / D.O. / P.A. / N.P.)**

>>>That physician's phone # (_____) _____-________

Please describe the reason for your evaluation today? (Chief Complaint / Symptoms)

____

⇒Where on your body is your problem or pain located? (be specific): ____

⇒ How would you describe your problem or pain? Ache / Burn / Radiate / Tingle / Migrate / Other (please specify):

⇒ On a scale of 1 to 10, with 10 being the most severe how would you rate this problem or pain? 1 2 3 4 5 6 7 8 9 10 ..or N/A

⇒ How long have you had this problem? ____days ____weeks ____months ____years

⇒ Was there an act that brought on the problem, pain, or symptom? ____

⇒ Describe anything that makes the pain or problem worse: ____

⇒ Does anything make the pain or problem better? ____

⇒ Have you taken any medication for your symptoms? NO / YES = ____

Please indicate any TESTING / PROCEDURES that you have had done for your CHIEF COMPLAINT

⇒ ***All test results/ medical records must be forwarded to our office before we may confirm your appointment.***

TEST / EXAMINATION	WHERE IT WAS PERFORMED	DATE(S)
Blood / Lab Studies		
X-rays; GI Studies		
CT Scan		
MRI		
Pet CT Scan		
Ultrasonography		
Mammography		
Colonoscopy		
EGD		
HIDA Scan		
Bone Scan		
BIOPSY		
SURGERY		
OTHER		

YOUR MEDICATION & SUPPLEMENT LIST MUST BE SUBMITTED ON *OUR FORM* INDICATED FOR SAME…

PHARMACY INFO: medications are ordered electronically; some medications require special consent

Retail Pharmacy Name: _________________________________ **Phone #** (_____) _____-__________
Pharmacy address: ____

Mail-Order Pharmacy Name: _____________________________ **Phone #** (_____) _____-_________
Pharmacy address: ____

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My signature below verifies that the information provided on this document is accurate as of today's date; I authorize the physician to proceed with evaluation and treatment of my chief complaint:

Patient's PRINTED name: ____ Date of Birth: ___________

SIGNATURE: ____ ________________________

SIGNATURE OF: ***(PLEASE CIRCLE)*** Patient / Parent / Legal Guardian / Patient Advocate Date

REVIEW OF SYSTEMS / MEDICAL HISTORY:

Constitutional:

Weight Gain	**NO**	**YES=amount:____**
Weight Loss	**NO**	**YES=amount:____**
Fever	**NO**	**YES**
Chills	**NO**	**YES**

Eyes:

Blurry Vision	**NO**	**YES**
Double Vision	**NO**	**YES**
Eye Pain	**NO**	**YES**

Ears, Nose, Throat:

Ear Infection	**NO**	**YES**
Sinus Problems	**NO**	**YES**
Sore Throat	**NO**	**YES**
Difficulty Swallowing	**NO**	**YES**

Cardiovascular:

A-Fib (atrial fibrillation)	**NO**	**YES**
High Blood Pressure	**NO**	**YES**
Heart Murmur	**NO**	**YES**
Heart Attack	**NO**	**YES date________**
High Cholesterol / Lipids	**NO**	**YES**
Clotting Disorder:__________	**NO**	**YES**
Thrombosis:______________	**NO**	**YES date________**
Varicose Veins	**NO**	**YES**
Leg Swelling	**NO**	**YES**
Pacemaker / ICD	**NO**	**YES**

Gastrointestinal:

Nausea	**NO**	**YES**
Vomiting	**NO**	**YES**
Constipation	**NO**	**YES**
Diarrhea	**NO**	**YES**
Ulcers	**NO**	**YES**
Change in bowel habits	**NO**	**YES**
Blood/Mucus in Stool	**NO**	**YES**
Diverticulosis	**NO**	**YES**
Heartburn/Reflux	**NO**	**YES**
Cirrhosis	**NO**	**YES**

Genitourinary:

Painful Urination	**NO**	**YES**
Urinary Frequency	**NO**	**YES**
Urinary Retention	**NO**	**YES**
Blood in Urine	**NO**	**YES**
Genital Disorder	**NO**	**YES**
Kidney Stones	**NO**	**YES**
Kidney Failure	**NO**	**YES**

Musculoskeletal:

Joint Pain	**NO**	**YES**
Neck Pain	**NO**	**YES**
Back Pain	**NO**	**YES**

Oncology

Cancer type / location:______________________

Date of Diagnosis: ______________

Chemotherapy **NO** **YES=***date(s)*_____________

Radiation **NO** **YES=***date(s)*_____________

Integument (skin):

Skin Rash	**NO**	**YES**
Boils	**NO**	**YES**
Warts	**NO**	**YES**
Moles	**NO**	**YES**
Persistent Itching	**NO**	**YES**

Neurological:

Tremors	**NO**	**YES**
Dizzy Spells	**NO**	**YES**
Numbness: _________________	**NO**	**YES**
Tingling: ___________________	**NO**	**YES**
Seizure:____________________	**NO**	**YES**
Stroke	**NO**	**YES date__________**
Nerve Loss: ________________	**NO**	**YES**

Respiratory:

Asthma	**NO**	**YES**
Bronchitis	**NO**	**YES**
Pneumonia	**NO**	**YES**
Emphysema / COPD	**NO**	**YES**
Persistent Cough	**NO**	**YES**
Sleep Apnea	**NO**	**YES**

Endocrine:

Excessive Thirst	**NO**	**YES**
Hot or Cold Spells	**NO**	**YES**
Tired	**NO**	**YES**
Sluggish	**NO**	**YES**
Diabetes	**NO**	**YES…**
Insulin dependent?	**NO**	**YES**
Obesity	**NO**	**YES**
Thyroid Disease (hypo / hyper)	**NO**	**YES**
Parathyroid Disease	**NO**	**YES**

Lymphatic:

Swollen Glands	**NO**	**YES**
Blood Clotting	**NO**	**YES date________**

Hematologic:

Anemia	**NO**	**YES**
Bleeding Disorder	**NO**	**YES**
Hepatitis A – B – C	**NO**	**YES**
HIV – AIDS	**NO**	**YES**

Psychological:

Bi-Polar	**NO**	**YES**
Depression /Anxiety	**NO**	**YES**
Drug Addiction:______________	**NO**	**YES**
Alcohol Abuse:_____________	**NO**	**YES**

Are you *pregnant*? **NO** **YES…**

If yes, how many weeks along are you? _______

Post-partum? **NO** **YES…**

If yes, Date of delivery? ______________

vaginal or c-section (circle)

Currently Breastfeeding? **NO** **YES**

OTHER: ____

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SIGNATURE: ____ _______________________

SIGNATURE OF: ***(PLEASE CIRCLE)*** Patient / Parent / Legal Guardian / Patient Advocate Date

SURGICAL HISTORY: Please list all surgeries you have had and their approximate date(s)

SURGERY / PROCEDURE	DATE	*SURGERY / PROCEDURE*	DATE

ALLERGIES:

Are you allergic to LATEX? No YES=reaction: ______________________________

Are you allergic to IODINE? No YES=reaction: ______________________________

Please list ALL DRUG ALLERGIES (& reactions): ______________________________

____

____

____

FAMILY CANCER HISTORY: Please list all cancer diagnoses for each blood relative; include age at time of diagnosis

Mother: ______________________________

Father: ______________________________

Sister(s): ______________________________

Brother(s): ______________________________

Daughter(s): ______________________________

Son(s): ______________________________

Maternal GrandMother: ______________________________

Maternal GrandFather: ______________________________

Maternal Aunt(s): ______________________________

Paternal GrandMother: ______________________________

Paternal GrandFather: ______________________________

Paternal Aunt(s): ______________________________

SOCIAL HISTORY – LIFETIME:

TOBACCO / NICOTINE USE: NO YES=circle**:** CIGARETTE / CIGAR / PIPE / CHEW / VAPE

Amount / Frequency: ______________________________

When did you start? ______________ When did you Quit? ______________

ALCOHOL USE: NO YES=***# of drinks*** ________ per DAY / WEEK / MONTH / YEAR ***Types:*** BEER / WINE / LIQUOR

Have you quit drinking? NO YES=*when did you quit?* ______________

CBD / MARIJUANA USE: NO YES= ***Type /Amount / Frequency***: ______________________________

OTHER / "STREET DRUGS": NO YES=***type / amount / frequency***: ______________________________

BLOOD TRANSFUSION PROTOCOL:

Do you have a **religious** –or- **personal** belief that prevents you from receiving blood or blood products? **NO YES =** ______________

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SIGNATURE: ______________________________ ______________

SIGNATURE OF: ***(PLEASE CIRCLE)*** Patient / Parent / Legal Guardian / Patient Advocate Date