PATIENT INTAKE HISTORY

PATIENT INFORMATION

NAME: ____

ADDRESS:____

DATE OF BIRTH: _______/_______/_______

HOME #: ( ) ______________________________

IS IT OKAY TO LEAVE A MESSAGE? □YES □ NO

WORK #: ( ) ______________________________

MAY WE CONTACT YOU AT WORK? □ YES □ NO
IS IT OKAY TO LEAVE A MESSAGE? □ YES □ NO

MOBILE # ( ) ______________________________

IS IT OKAY TO LEAVE A MESSAGE? □YES □ NO

EMPLOYER: ____

REFERRING PHYSICIAN/OB/GYN:____

PRIMARY CARE PROVIDER:____

PREFERRED PHARMACY:____

E-MAIL ADDRESS:____

PATIENT INTAKE HISTORY (Continued)

PATIENT NAME:	DATE: / /

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

PERSONAL PAST HISTORY OF ILLNESSES

MAJOR ILLNESSES	YES (DATE)	NO	PHYSICIAN/NURSE NOTES
ASTHMA			
PNEUMONIA/LUNG DISEASE			
TUBERCULOSIS			
HEART ATTACK/PROBLEMS			
HIGH BLOOD PRESSURE			
STROKE			
BLOOD CLOTS IN LUNGS OR LEGS			
KIDNEY INFECTIONS/STONES			
SEXUALLY TRANSMITTED DISEASE			
HIV/AIDS			
THYROID DISEASE			
DIABETES			
EATING DISORDERS			
DEPRESSION/ANXIETY			
ARTHRITIS/JOINT PAIN/BACK PROBLEMS			
COLLAGEN VASCULAR DISEASE (LUPUS)			
CANCER			
REFLUX/HIATAL HERNIA/ULCERS			
HEPATITIS/JAUNDICE/LIVER DISEASE			
GALLBLADDER DISEASE			
COLITIS/CROHN'S DISEASE			
ANEMIA			
BLOOD TRANSFUSIONS			
MIGRAINE HEADACHES			
SEIZURES/CONVULSIONS/EPILEPSY			
OTHER			

INJURIES/ILLNESSES – IF NONE CHECK HERE - ☐

REASON	DATE OR YEAR	HOSPITAL

OPERATIONS/HOSPITALIZATIONS – IF NONE CHECK HERE - ☐

SURGERY/REASON	DATE OR YEAR	HOSPITAL

PATIENT INTAKE HISTORY (Continued)

PATIENT NAME:	DATE: / /

FAMILY HISTORY

MOTHER: ☐ LIVING ☐ DECEASED – CAUSE: AGE:			FATHER: ☐ LIVING ☐ DECEASED – CAUSE: AGE:
SIBLINGS: NUMBER LIVING: NUMBER DECEASED:			CAUSE(S)/AGES(S):
CHILDREN: NUMBER LIVING: NUMBER DECEASED:			CAUSE(S)/AGES(S):
ILLNESS	**YES**	**WHICH RELATIVE(S) AND AGE OF ONSET**	**PHYSICIAN/NURSE NOTES**
DIABETES			
STROKE			
BLOOD CLOTS IN LUNGS OR LEGS			
HEART DISEASE			
HIGH BLOOD PRESSURE			
HIGH CHOLESTEROL			
OSTEOPOROSIS (WEAK BONES)			
RECURRENT MISCARRIAGE			
INFERTILITY			
BIRTH DEFECTS			
BREAST CANCER			
COLON CANCER			
OVARIAN CANCER			
UTERINE CANCER			
OTHER			

SOCIAL HISTORY

	PHYSICIAN/NURSE NOTES
EVER SMOKE? ☐ YES ☐ NO	
CURRENT SMOKING: PACKS PER DAY: HOW MANY YEARS:	
IF YOU ARE CURRENTLY SMOKING, ARE YOU READY TO QUIT? ☐ YES ☐ NO	
ALCOHOL: DRINKS PER DAY: DRINKS PER WEEK:	
RECREATIONAL DRUG USE? ☐ YES ☐ NO	
HAVE YOU BEEN SEXUALLY ABUSED, THREATENED, OR HURT BY ANYONE? ☐ YES ☐ NO	
OCCUPATION/JOB:	
EDUCATION COMPLETED: ☐ HIGH SCHOOL ☐ SOME COLLEGE ☐ COLLEGE /BA DEGREE ☐ GRADUATE DEGREE ☐ OTHER	

OBSTETRIC HISTORY - IF NO PREGNANCIES PLEASE CHECK HERE - ☐

	NUMBER		**NUMBER**		**NUMBER**
PREGNANCIES		ABORTIONS		MISCARRIAGES	
PREMATURE BIRTHS (<37 WEEKS)		LIVE BIRTHS		LIVING CHILDREN	

#	BIRTH DATE	BIRTH WEIGHT	SEX	WEEKS PREGNANT	TYPE OF DELIVERY (VAGINAL, CESAREAN, ETC.)	COMPLICATIONS
1.						
2.						
3.						

PATIENT INTAKE HISTORY (Continued)

PATIENT NAME:	DATE: / /

CURRENT MEDICATIONS – IF NONE CHECK HERE - ☐
(Including hormones, vitamins, herbs, nonprescription medications)

CURRENT MEDICATIONS	DOSAGE	WHO PRESCRIBED		CURRENT MEDICATIONS	DOSAGE	WHO PRESCRIBED

MEDICATION ALLERGIES or OTHER ALLERGIES – IF NONE CHECK HERE - ☐

ALLERGY	TYPE OF REACTION

PATIENT INTAKE HISTORY (Continued)

PATIENT NAME:	DATE: / /

PERSONAL PROFILE

MARITAL STATUS:	☐ MARRIED ☐ LIVING WITH PARTNER ☐ SINGLE ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED
NUMBER OF PRIOR MARRIAGES FOR YOU AND PARTNER:	
HOW LONG HAVE YOU BEEN MARRIED OR LIVING WITH CURRENT PARTNER?	
SEXUAL ORIENTATION:	☐ HETEROSEXUAL ☐ HOMOSEXUAL ☐ BISEXUAL

GYNECOLOGIC HISTORY

	PHYSICIAN /NURSE NOTES
LAST NORMAL MENSTRUAL PERIOD (FIRST DAY):	
AGE PERIODS BEGAN:	
HOW OFTEN DO YOU GET PERIODS:	
LENGTH OF YOUR PERIOD (NUMBER OF DAYS OF BLEEDING):	

	YES	NO	PHYSICIAN/NURSE NOTES
ANY RECENT CHANGES IN YOUR PERIODS?			
ARE YOUR PERIODS HEAVY?			
DO YOU BLEED BETWEEN PERIODS?			
DO YOU BLEED AFTER INTERCOURSE?			
DO YOU HAVE PAINFUL PERIODS?			
HAVE YOU HAD A SEXUALLY TRANSMITTED DISEASE?			
HAVE YOU HAD PELVIC INFLAMMATORY DISEASE (PID)?			
DATE OF YOUR LAST PAP TEST:			
WAS IT NORMAL?			
HAVE YOU EVER HAD AN ABNORMAL PAP TEST?			
DO YOU HAVE PELVIC PAIN?			
DO YOU HAVE ENDOMETRIOSIS?			
DO YOU HAVE FIBROIDS?			
DO YOU HAVE PAIN WITH INTERCOURSE?			
PREVIOUS METHOD(S) OF BIRTH CONTROL: ☐ BIRTH CONTROL PILLS ☐ IUD ☐ DEPO PROVERA ☐ NUVARING ☐ TUBAL LIGATION ☐ VASECTOMY ☐ CONDOMS			

ENDOCRINE HISTORY

	YES	NO	PHYSICIAN/NURSE NOTES
HAS YOUR WEIGHT CHANGED?			
DO YOU HAVE EXCESS HAIR GROWTH?			
DO YOU HAVE ACNE?			
DO YOU HAVE NIPPLE DISCHARGE?			
DO YOU HAVE HOT FLASHES?			
DO YOU HAVE A HISTORY DES EXPOSURE?			

PATIENT INTAKE HISTORY (Continued)

PATIENT NAME:	DATE: / /

REVIEW OF SYSTEMS
Please check (x) if any of the following symptoms apply to you now or since adulthood
If you are not sure, please put a (?) next to the symptom

	NO	NOW	PAST	PHYSICIAN/NURSE'S NOTES
CONSTITUTIONAL				
FEVER	□	□	□	
EYES				
DOUBLE VISION	□	□	□	
VISION CHANGES	□	□	□	
GLASSES/CONTACTS	□	□	□	
SPOTS BEFORE EYES	□	□	□	
EAR, NOSE, AND THROAT				
MOUTH SORES	□	□	□	
CARDIOVASCULAR				
CHEST PAIN OR PRESSURE	□	□	□	
DIFFICULTY BREATHING ON EXERTION	□	□	□	
SWELLING OF LEGS	□	□	□	
RAPID OR IRREGULAR HEARTBEAT	□	□	□	
RESPIRATORY				
WHEEZING/ASTHMA	□	□	□	
SPITTING UP BLOOD	□	□	□	
SHORTNESS OF BREATH	□	□	□	
CHRONIC COUGH	□	□	□	
GASTROINTESTINAL				
FREQUENT DIARRHEA	□	□	□	
BLOODY STOOL	□	□	□	
NAUSEA/VOMITING/INDIGESTION	□	□	□	
CONSTIPATION	□	□	□	
INVOLUNTARY LOSS OF GAS OR STOOL	□	□	□	
GENITOURINARY				
BLOOD IN URINE	□	□	□	
PAIN WITH URINATION	□	□	□	
FREQUENT URINATION	□	□	□	
MUSCULOSKELETAL				
MUSCLE WEAKNESS	□	□	□	
MUSCLE OR JOINT PAIN	□	□	□	
SKIN				
RASH	□	□	□	
SORES	□	□	□	
MOLES	□	□	□	
BREASTS				
LUMPS	□	□	□	
NEUROLOGIC				

PATIENT INTAKE HISTORY (Continued)

PATIENT NAME:	DATE: / /

DIZZINESS	☐	☐	☐	
SEIZURES	☐	☐	☐	
NUMBNESS	☐	☐	☐	
SEVERE MEMORY PROBLEMS	☐	☐	☐	
FREQUENT OR SEVERE HEADACHES	☐	☐	☐	
DEPRESSION OR FREQUENT CRYING	☐	☐	☐	
SEVERE ANXIETY	☐	☐	☐	
WOULD YOU LIKE A REFERRAL TO A COUNSELOR?	☐	☐	☐	
ENDOCRINE				
HAIR LOSS	☐	☐	☐	
DIABETES	☐	☐	☐	
HEAT OR COLD INTOLERANCE	☐	☐	☐	
ABNORMAL THIRST	☐	☐	☐	
HEMATOLOGIC/LYMPHATIC				
FREQUENT BRUISES	☐	☐	☐	
CUTS THAT DO NOT STOP BLEEDING	☐	☐	☐	
ENLARGED LYMPH NODES (GLANDS)	☐	☐	☐	