

New Patient Intake Form - Adult

ame: DOB:			DOB:	Date:				
Previous Primary Care Provider:				Last Visit:				
What is the primary reason for	your v	isit today:						
Social History:								
Iarital Status: Occupation:				Religion:				
Tobacco Use: Cigarettes Pip	e Cig	ars Chew	NONE	Year Starte	d:/ Qւ	uit: Amount/Day:		
Alcohol/Recreational Drug Use	e: (Typ	e/Amount/	Frequency	/)				
Caffeine: (Type/Amount)		/Day	Special I	Diet:				
Exercise Type/Frequency:				# Hrs Sleep per night:				
Do you have Living Will/Adva	inced E	Directive:	Yes No	If not, are	e you intere	ested in information? Yes No		
Do you feel safe in your home environment? Yes No Concerns regarding abuse: Yes No						abuse: Yes No		
Family/Past Medical Histor	y :							
Have YOU or family member	rs been	diagnosed	l with any	of the follo	owing: chec	ck as appropriate		
	Self	Father	Mother	GrdPrnt	Brother	Sister		
Alcohol/Substance Abuse								
Allergies (Hayfever)								
Anemia/Bleeding Disorder								
Arthritis	\Box							
Asthma								
Cancer								
Cholesterol disorder	님		\square		\square			
COPD/ Lung problems	님	\vdash	\vdash		\vdash			
Depression/Anxiety	님			\square				
Diabetes	님	\vdash	H	\vdash	\mathbb{H}			
Headaches	H	\vdash	H		H			
Heart Problem	H	H	H		H			
High blood pressure Kidney/Bladder Problems	H	H		H		H		
Mental/Psychiatric Problems	H	H	H	H	H	H		
Osteoporosis	H		H		H	H		
Seizures/Neurologic Problem	H	H	H	H	H	H		
Stomach/Digestive Problem	H	H	H		H	H		
Stroke	H	H	H	H	H	H		
Thyroid Disorders	H	H	H	H	H	H		
,								

Surgeries/Hospitalization/s: (List What & Year)						
Preventative Care	/Immunizations: Please li	st Most Recent: Pl	nysical Exam:			
Dental Exam:	Eye Exam:	Labwork:	_ Colonoscopy:			
Dexa Scan:	Prostate Exam:	Mammogram:	Pap Smear:			
Flu Shot:	Pneumonia Shot:	Tetanus Shot:	Zoster (Shingles):			
Hepatitis B:	Hepatitis A:	HPV:				
Females: Pregna	ant? Yes No Age o	of First Period?	Regular periods? Yes No			
# of: Pregnancies:	Live births: N	Miscarriages: Abo	ortions: Living children:			
Date of Last Menst	rual Period: C	Current Form of Birth Co	ontrol:			
Current Medicati	ons: Include Prescription ar	nd Non-Prescription, Inh	alers, Vitamins, Etc.			
Medication:	Strength/Times Per D	ay: For What:	Prescribed By:			
Allergies to Medic	eations: None					

Review of Systems: Please circle any of the symptoms you are currently experiencing:

General:

Fever/Chills Decreased Energy Change in Appetite Night Sweats

Loss/Gain 10 lbs or more

Eves/Ears/Nose/Throat:

Vision/Hearing Changes Ear/Eye Pain Ringing in ears Nose Bleeds Sinus Problems Sore Throat Hoarseness

Heart:

Chest Pain

Irregular Heart Beat Heart Murmur Swelling in legs, feet Poor Circulation

Respiratory:

Shortness of Breath

Wheezing Coughing

Tuberculosis Exposure

Gastrointestinal:

Frequent Heartburn
Difficulty Swallowing
Abdominal Pain
Nausea/Vomiting
Diarrhea

Constipation

Blood in Bowel Movements

Genitourinary:

Blood in Urine Foul Odor

Burning when urinating Increased Urinary frequency

Frequent Infections MALES: Hesitancy

Gynecologic (FEMALES): Pain with intercourse

Pain with periods

Skin:

Hair Loss Sores/Ulcers Itching Nail Changes Color Changes Rashes

Excessive Dryness

Changes in Moles/Growths

Musculoskeletal:

Neck/Back Pain Broken Bones Osteoporosis Muscle Weakness Swollen Joints Joint Pain/Ache Frequent Leg cramps Breast Pain (Males & Females)

Endocrine:

Heat/Cold Intolerance Increased Thirst Excess Sweating **Neurological:**

Numbness Weakness Headaches Dizziness/Vertigo Loss of Balance Paralysis Seizures

Heme/Lymphatic:

Easy Bruising Blood Clots

Tremors

Swollen Lymph Nodes

Allergic/Immunologic:

Hayfever (Seasonal Allergy) Hepatitis B C D

HIV Positive Positive TB / PPD Frequent Infections

Psychiatric:

Depression Anxiety Insomnia Hallucinations

Alcohol/Drug Dependence

Suicidal Thoughts

Functional:

Incontinence of Bladder or Bowel Assistance needed for daily care Dependent upon others for

transportation