Medical Intake Form

Please complete all of the following as accurately as possible:

Name _____ Age_____ Birth date _____ Sex_____

Address_____ City_____ Zip_____

Phone (H) _____ Work_____

Occupation_____ Full Time/ Part Time

Employer_____ Education Level_____

Married_____ Separated_____ Divorced_____ Widow_____ Single_____ Other_____

Children (ages) _____

How did you hear about us? _____

Race_____ Ethnicity_____ Language_____

Please list your most concerning health care problems at this time (in order of importance to you):

1. _____
2. _____
3. _____
4. _____
5. _____

When did your chief problem or illness begin? _____

What do you think may have caused your chief complaint? _____

_____

What experiences in your life have affected you deeply? _____

_____

Past surgical History:

Please list any Surgical Procedures you have had and the approximate dates:

	Problem	***Dates***
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Past Medical History:

Please list any serious medical conditions for which you have been treated/ hospitalized in the past:

	Problem	***Dates***
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Specifically, please place a check next to any of the following that you have had:

_____ Heart Disease

_____ Stroke

_____ Diabetes

_____ Hypertension

_____Asthma

_____ Allergies

_____ Eczema

____ Depression

____ Sexually Transmitted Disease

____ HIV/ AIDS

____ Tuberculosis (TB)

____ Polio

____ Cancer

____ Major Trauma

Family History:

Please circle any of the following diseases tend to run in your family and list what relative (father, grandmother, etc)

Diabetes_____ Cancer _____

Heart Disease _____ Asthma _____

Stroke _____ Allergies _____

High blood pressure _____ Eczema _____

Seizures _____ Blood Disorder _____

Social History:

Please check beside any of the following you have used in the past or currently:

_____ Alcohol (beer, wine or spirits) _____ Tobacco (cigarettes, cigar, pipe)

_____ Illegal Drugs _____ Tobacco (chewing)

_____ Birth Control _____ Coffee

_____ Vitamins / Supplements _____ Herbal Products

Medications:

List all of the Prescription Medicines or Over the Counter Drugs you are now taking:

_____

_____

Allergies:

Please list any medications to which you are allergic:

_____

Please list any foods that you are allergic or sensitive:

_____

Food Cravings:

Please list any strong food cravings or favorite foods:

_____

Please List any strong food aversion or foods you avoid:

_____

Review of Systems:

Please put a check in the space next to any symptoms you currently have, or have had in the past:

General:

Now	Past		Now	Past	
____	____	Warm Blooded Person	____	____	Thirsty
____	____	Chilly Person	____	____	No Thirst
____	____	Tend to Perspire Easily	____	____	Weight loss or gain
____	____	Sensitive to wind	____	____	affected by change in weather

HEENT:

Now	Past		Now	Past	
____	____	Headaches	____	____	Eye Problems
____	____	Hair Loss	____	____	Sensitive to light
____	____	Head Injury	____	____	Sinus Infections
____	____	Seizures	____	____	Nose Allergy
____	____	Dizziness	____	____	Loss of Smell
____	____	Vertigo	____	____	Frequent Cavities
____	____	Balance Problems	____	____	Teeth Problems
____	____	Hearing Problems	____	____	grinding the teeth
____	____	Ringing in Ears	____	____	Mouth Ulcers
____	____	Sensitive to Noise	____	____	Gum Problems
____	____	Ear Infections	____	____	Taste in mouth
____	____	Discharge from Ear	____	____	Loss of taste
____	____	Retina Problems	____	____	Sore throats
____	____	Wear Glasses	____	____	Swallowing problems
____	____	Glaucoma	____	____	Tonsillitis
____	____	Cataracts	____	____	Loss of voice

Neck:

Now	Past		Now	Past	
____	____	Neck Injury	____	____	Thyroid Problems
____	____	Neck Pain	____	____	Swollen Glands

Respiratory:

Now	Past		Now	Past	
____	____	Asthma	____	____	Wheezing
____	____	Pneumonia	____	____	Phlegm (frequent)
____	____	Bronchitis	____	____	Short of breath
____	____	Persistent Cough	____	____	Fluid in Chest

Heart:

Now	Past		Now	Past	
____	____	Heart Attack	____	____	Chest Tightness
____	____	Angina	____	____	Palpitations
____	____	Heart Valve Problem	____	____	Irregular Heartbeat
____	____	Chest Pain	____	____	Ankle or leg swelling

GI:

Now	Past		Now	Past	
____	____	Stomach Ulcer	____	____	Bloating
____	____	Gastritis	____	____	Liver Problems
____	____	Reflux	____	____	Diarrhea Tendency
____	____	Heartburn	____	____	Constipation Tendency
____	____	Frequent Nausea	____	____	Blood in stool
____	____	Frequent Vomiting	____	____	Hemorrhoids
____	____	Indigestion	____	____	Fissures
____	____	Belching	____	____	Rectal Itching
____	____	Gas	____	____	Parasites

GU:

Now	Past		Now	Past	
____	____	Frequent Urination	____	____	Waking to Urinate
____	____	Painful Urination	____	____	Incontinence
____	____	Difficulty urinating	____	____	Blood in urine

Male:

Now	Past		Now	Past	
____	____	Prostate Problems	____	____	Testicle pain or swelling
____	____	Erection problems	____	____	Infertility
____	____	Discharge from penis	____	____	Varicocele

Female:

Now	Past		Now	Past	
____	____	Vaginal discharge	____	____	Long lasting periods
____	____	Few or no orgasms	____	____	Bleeding between periods
____	____	Painful intercourse	____	____	Fibroids
____	____	Vaginal itching	____	____	Ovarian Cysts
____	____	Premenstrual Syndrome (PMS)	____	____	Endometriosis
____	____	Heavy periods	____	____	Menopausal problems
____	____	Irregular Periods			

Age menstruation began: _____
How frequent are periods: every _____ days.
How long do periods usually last? _____ Days.

Number of pregnancies _____ Number of Births _____ Miscarriages _____ Abortions _____

Musculoskeletal:

Now	**Past**				
____	____	Muscle Pain	____	____	Broken Bones
____	____	Joint Pain	____	____	Numbness or Tingling
____	____	Bone Pain	____	____	Weakness in arms/legs

Skin:

Now	**Past**				
____	____	Rough or Dry Skin	____	____	Hives
____	____	Rashes	____	____	Boils/ Abscesses
____	____	Itching	____	____	Acne
____	____	Warts	____	____	Nail Problems

Sleep:

Now	**Past**				
____	____	Difficulty falling asleep	____	____	waking to early
____	____	Nightmares	____	____	Sleep apnea
____	____	waking frequently			

Mental/ Emotional:

Now	**Past**				
____	____	Memory Problems	____	____	Irritability
____	____	Confusion	____	____	Anger problems
____	____	Difficulty Concentrating	____	____	Mood swings
____	____	Impulsive	____	____	Depression/ Sadness
____	____	Restlessness	____	____	Hallucinations
____	____	Nervousness/ Anxiety	____	____	Feelings of Euphoria
____	____	Strong fears			

Please list and specific fears that you have: _____

_____

Please provide any further clarifying information here: _____

_____

_____

_____