Patient Intake Form

Name:____
(Last) (First) (Middle)
Date: ________________________

Date of Birth:______________ Age: _______Social Security #: ___________________________

Referring Physician: ____________________Primary Care Physician: ______________________

Address/Phone: ________________________________

Chief Complaint: (Why do you want to see the Doctor?) Injury Date:______________________

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Tuberculosis	Yes No	Alcoholism	Yes No	Hepatits	Yes No
Asthma	Yes No	Drug Abuse	Yes No	Liver Disease/Cirrhosis	Yes No
Lung Disease/COPD	Yes No	Mental Illness	Yes No	Kidney Disease	Yes No
High Blood Pressure	Yes No	Depression	Yes No	Stomach Ulcer/Reflux	Yes No
Heart Disease	Yes No	Diabetes	Yes No	Epilepsy/Seizure	Yes No
Stroke	Yes No	Arthritis/Gout	Yes No	Thyroid Disease	Yes No
Bleeding Tendency	Yes No	Cancer	Yes No	Blood Clots	Yes No

Hospitalization? Yes No
Other Medical Problems? Yes No
If yes, please describe: ____

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Previous Surgeries:

1.____________________________________ **4.** ______________________________________

2.____________________________________ **5.** ______________________________________

3.____________________________________ **6.** ______________________________________

Review of Systems:
Do you have or have you ever had:

Significant weight change? Loss or Gain?	Yes No	Incontinence or frequent urination?	Yes No
Any eye disease, injury, impaired sight?	Yes No	Loss of bladder control?	Yes No
Any ear disease, injury, impaired hearing?	Yes No	Anxiety or mood swings?	Yes No
Trouble swallowing?	Yes No	Muscle weakness in arm or leg?	Yes No
Shortness of Breath?	Yes No	Numbness/tingling?	Yes No
Chest Pain or tighness in the chest?	Yes No	Paralysis?	Yes No
Difficulty lying flat?	Yes No	Pain in joint or gout?	Yes No
Swelling of hands or feet?	Yes No	Decreased mobility?	Yes No
Stomach trouble/ulcer/reflux?	Yes No	Skin irritation or rash?	Yes No
Constipation or diarrhea?	Yes No		