NEW PATIENT INTAKE AND HISTORY FORM
(Please print)

Today's Date: _____
Name: _____ **Date of Birth:** _____

Local Pharmacy: _____
(Name/City/Phone #)
Mail Order Pharmacy: _____
(Name/City/Phone #)

REASON FOR COMING TO THE DOCTOR TODAY:
Reason for Today's Visit: _____

Timing/Onset: When did symptoms first occur? _____
Duration: Frequency of symptoms? _____
Characterized as/Severity: Describe the severity of the symptoms/pain. _____
Associated Signs and Symptoms: Are there any other symptoms associated with your problem? _____
_____
Modifying Factors: What makes the condition better and/or worse? _____
Other Physicians/Specialists seen? _____

PROBLEM LIST/PAST MEDICAL HISTORY:
Have you been diagnosed with any of the following (currently or in the past)?

☐ Anemia	☐ Congestive Heart Failure	☐ Gout	☐ Obesity
☐ Anxiety	☐ COPD	☐ Heart Murmur	☐ Pneumonia
☐ Arthritis	☐ Crohn's Disease	☐ Hepatitis	☐ Rheumatic Fever
☐ Asthma	☐ Depression	☐ High Blood Pressure	☐ Seasonal Allergies
☐ Coronary Artery Disease	☐ Diabetes – Type 1	☐ High Cholesterol	☐ Seizures
☐ Cancer	☐ Diabetes – Type 2	☐ History of Blood Clots	☐ Shingles
☐ Cataract	☐ Gastric Reflux	☐ HIV	☐ Stroke
☐ Chronic Kidney Disease	☐ Genital Herpes	☐ Irritable Bowel Syndrome	☐ Thyroid Disorder
☐ Congestive Heart Disease	☐ Glaucoma	☐ Migraine	

☐ Other: _____

ALLERGY HISTORY:
☐ **None** ☐ **NKDA (No Known Drug Allergies)**

☐ ACE Inhibitors	☐ Codeine/Codeine Derivatives	☐ Iodinated Contrast Media	☐ NSAIDS
☐ Acetaminophen	☐ Epinephrine	☐ Local Anesthetics (Ester-Lidocaine)	☐ Sulfa Drugs

_____
_____
_____

MEDICATION HISTORY:

☐ I am not currently taking any medications

List any medications, vitamins, minerals, and herbals that you are currently taking:

Name of Medication	Dosage	How Often

FAMILY HISTORY:

Has any member of your family been diagnosed with any of the following conditions (include deceased family members)? Place an "X" under the correct family member with the condition and indicate if the family member passed away due to that condition.

	Mother	Father	Sister	Brother	Mother's Parents	Father's Parents
Arthritis						
Asthma						
Cancer						
Cataract						
COPD						
Depression						
Diabetes						
Heart Disease						
High Blood Pressure						
High Cholesterol						
Kidney Disease						
Obesity						
Osteoporosis						
Seizures						
Thyroid Problems						
Tuberculosis (TB)						

Other:_____

PAST SURGICAL HISTORY:

☐ **None**

☐ Angioplasty (stent)	☐ Cholecystectomy	☐ Hip Replacement, Right	☐ Shoulder Replacement, Left
☐ Appendectomy	☐ Circumcision	☐ Hysterectomy	☐ Shoulder Replacement, Right
☐ Back Surgery	☐ Coronary Art. Bypass	☐ Knee Replacement, Left	☐ Sinus Surgery
☐ Breast Surgery	☐ Ear Tubes	☐ Knee Replacement, Right	☐ Thyroidectomy
☐ Cataract Extraction, Left	☐ Hemorrhoidectomy	☐ Neck Surgery	☐ Tonsillectomy
☐ Cataract Extraction, Right	☐ Hernia Repair	☐ Ovary Removal, Left	☐ Tubal Ligation
☐ Cesarean Delivery	☐ Hip Replacement, Left	☐ Ovary Removal, Right	

Other:_____

SOCIAL HISTORY:

Please describe your current tobacco use:

☐ Smoker, current status unknown ☐ Light tobacco smoker ☐ Heavy tobacco smoker ☐ Current every day smoker
☐ Current some day smoker ☐ Former smoker ☐ Never smoker ☐ Unknown if ever smoked

If you currently use tobacco or have in the past, please indicate what type (cigarettes, cigars, pipe, chew) and how many years: _____

Do you drink alcoholic beverages? ☐ Yes ☐ No

If yes, please indicate what type of beverage and how many times per week: _____

Have you ever used any illicit drugs? ☐ Yes ☐ No

If yes, please indicate what type of drug and how often: _____

REVIEW OF SYSTEMS:

Please place a check mark in the box next to any of the following symptoms or problems if you have experienced them recently or have concerns about them. If you don't understand something place a question mark "?" by it. Your doctor will discuss any positive responses with you.

General: ☐ **Normal**
- ☐ Fatigue
- ☐ Fever

Skin: ☐ **Normal**
- ☐ Rash

HEENT: ☐ **Normal**
- ☐ Nasal Congestion
- ☐ Sore Throat

Neck: ☐ **Normal**
- ☐ Neck Pain

Respiratory: ☐ **Normal**
- ☐ Cough
- ☐ Shortness of Breath

Breast: ☐ **Normal**
- ☐ Breast Pain

Cardiovascular: ☐ **Normal**
- ☐ Chest Pain
- ☐ Edema

Gastrointestinal: ☐ **Normal**
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting

Genitourinary: ☐ **Normal**
- ☐ Blood in Urine
- ☐ Frequency
- ☐ Painful Urination
- ☐ Menstrual Irregularities
- ☐ Pelvic Pain

Musculoskeletal: ☐ **Normal**
- ☐ Back Pain
- ☐ Joint Pain

Neurological: ☐ **Normal**
- ☐ Headaches
- ☐ Visual Changes

Psychiatric: ☐ **Normal**
- ☐ Anxiety
- ☐ Depression

Endocrine/Glands: ☐ **Normal**
- ☐ Appetite Changes
- ☐ Thyroid Problems

Hematology: ☐ **Normal**
- ☐ Easy Bruising