Patient Intake Form

Patient Name _____ **Visit Date** _____
Phone (home) _____ (work) _____ (cell) _____
E-mail address: _____

May we leave personal messages for you on your **voicemail?** ☐Yes ☐No **email?** ☐Yes ☐No

Marital Status: _____With whom do you live? _____

DOB ____/____/____ **Age**_____

Are you currently employed: ☐ No ☐ Yes ☐ Retired **Occupation**: _____

Referring physician (name and phone number):

_____

Primary Care Physician (name and phone number):

_____

Other physicians you would like us to keep informed (name and phone number):

_____

Reason for visit:

_____

Medical Information:

Height: _____Weight: _____ Recent weight loss? _____pounds _____months

Do you have pain? _____

Do you smoke now? No ☐ Yes ☐ Did you smoke in the past? No ☐ Yes ☐

When did you stop? _____ How many packs per day? _____ How many years? ____

About how much alcohol do you drink? None ☐ Occasionally ☐ 1 drink/day ☐

2-3 drinks/day ☐ More than 3 drinks/day ☐

Have you ever been treated for drug/alcohol addiction? No ☐ Yes ☐

Drug Allergies No ☐ Yes ☐ Please list:

_____
_____
_____

Medication List:

Current Medications:	For the Treatment of:	Dose	How Often?

Major Medical Problems (diabetes, heart, lung, blood pressure, scleroderma, connective tissue disorder):

_____

_____

_____

Prior Surgeries & Dates:

_____

_____

Hospitalizations & Dates:

_____

_____

Previous radiation treatment? No ☐ Yes ☐ When/Where?

_____

Previous or current chemotherapy? No ☐ Yes ☐ When/Where?

_____

_____

History of cancer in the family:

_____

_____

Pharmacy: _____ Phone**:** _____

Do you have an implanted medical device including, but not limited to, pacemakers, defibrillators, neurostimulators, drug infusion pumps or prostheses? No ☐ Yes ☐ please list type, manufacturer and physician contact information:

_____

_____

*We do not release information about you without your consent. If you wish to give us permission to speak freely with certain relatives or friends, please list their names and relationship to you.

_____

_____

Emergency Contact(s): Name, Relation, and Phone Number

_____

_____

Review of Systems

Are you currently experiencing or have you experienced any of the following symptoms **within the last 30 days?**

	Yes	NO
Constitutional		
Appetite change		
Fatigue		
Fever		
Weight Loss		
Eyes		
Eye Discharge		
Eye Pain		
Head/Ears/Nose/Throat		
Hearing loss		
Pain in ears		
Ringing in ears		
Nose bleeds		
Congestion		
Dental problem		
Sore Throat		
Trouble swallowing		
Voice change		
Respiratory		
Chronic cough		
Difficulty breathing		
Wheezing		
Cardiovascular		
Chest pain		
Leg Swelling		
Palpitations		
Pacemaker		
Gastrointestinal		
Abdominal pain		
Blood in stools		
Constipation		
Diarrhea		
Nausea		
Vomiting		
Genitourinary		
Difficulty urinating		
Burning upon urination		
Frequent urination		
Blood in urine		
Urgency		
Sexual activity		

	Yes	NO
Reproductive-Female		
Breast lumps		
Nipple discharge		
Estrogen Replacement (current or previous) – Years _____		
Last menstrual period /		
Age when periods began		
Number of pregnancies:		
Number of live births:		
Age at 1st birth:		
Musculoskeletal		
Joint Pain/arthritis		
Back Pain		
Problems walking		
Joint Swelling		
Skin		
Rash		
Wound		
Neurologic		
Dizziness		
Headaches		
Numbness		
Seizures		
Speech difficulty		
Fainting		
Weakness in arms or legs		
Hematologic		
Swollen lymph nodes		
Bruises/Bleed easily		
Immunology		
Rheumatoid arthritis		
Lupus		
Scleroderma		
Psychiatric		
Agitation		
Confusion		
Depressed mood		
Nervous/Anxiety		