Patient Intake Form

Patient Name: ______________________ Date of Birth: __________ Date: __________

Social History

Tobacco Use: ☐ No ☐ Yes ________ packs/day x ________ years
Alcohol Use: ☐ No ☐ Yes _____ C _____ A _____ G _____ E
Illicit Drug Use: ☐ No ☐ Yes type/quantity/frequency ______________
Marital Status: ☐ Single ☐ Married ☐ Civil Union ☐ Divorced ☐ Widow(er)
☐ Separated ☐ Partnered ☐ Other
Children: ☐ Boy(s) Age(s): __________ ☐ Girl(s) Age(s): __________
Student Status: ☐ Full-time ☐ Part-time ☐ Not applicable
Employment Status: ☐ Full-time ☐ Part-time ☐ Not currently working
Occupation: ______________________

Nutrition/Exercise

Level of Activity: ☐ None ☐ Occasional ☐ Regular ☐ Vigorous
Type of Exercise: ______________________
Ideal Weight Range: ______________________
Sig. Weight Change: ______________________

Review of Systems

Please mark the box if you have experienced the following symptoms in the last 6 months.

General
- ☐ weight gain
- ☐ weight loss
- ☐ fatigue
- ☐ insomnia
- ☐ fall in last 3 months

Endocrine
- ☐ heat intolerance
- ☐ cold intolerance
- ☐ diabetes
- ☐ thyroid problems

Eyes, Ears, Nose and Throat
- ☐ vision problems
- ☐ glaucoma
- ☐ ringing in ears
- ☐ difficulty swallowing
- ☐ hoarseness
- ☐ nose bleeds
- ☐ ear pain
- ☐ other __________

Gastrointestinal
- ☐ frequent diarrhea
- ☐ constipation
- ☐ ulcers/heartburn
- ☐ liver disease
- ☐ stomach pains

Musculoskeletal
- ☐ arthritis
- ☐ bone/joint pain
- ☐ gout
- ☐ other __________

Genitourinary
- ☐ frequency/urgency
- ☐ painful urination
- ☐ abnormal discharge
- ☐ nipple discharge
- ☐ decreased libido
- ☐ difficulty orgasming
- ☐ hypersexuality
- ☐ pain during sex

Respiratory
- ☐ shortness of breath
- ☐ asthma
- ☐ allergies
- ☐ chronic cough
- ☐ other __________

Immunologic
- ☐ HIV/AIDS
- ☐ allergies
- ☐ sinus trouble
- ☐ other __________

Cardiovascular
- ☐ chest pain
- ☐ irregular beat
- ☐ night sweats
- ☐ murmur
- ☐ leg swelling
- ☐ varicose veins
- ☐ high blood pressure
- ☐ cholesterol problems

Skin
- ☐ rashes
- ☐ easy bruising
- ☐ acne
- ☐ psoriasis
- ☐ hist. of skin cancer
- ☐ mole changes
- ☐ discoloration
- ☐ eczema

Neurological
- ☐ memory loss
- ☐ fainting
- ☐ dizziness
- ☐ vertigo
- ☐ headaches
- ☐ poor coordination
- ☐ hist. of stroke/TIA

Notes:

____

____

For office use only:

	Date:	Date:	Date:	Date:	Date:
Height:					
Weight:					
Blood Pressure:					
Pulse:					

Notes:

____

____

____