NEW PATIENT INTAKE FORM
HOSPITAL BASED CLINICS

Please answer all questions to the best of your ability.

Patient Name:____ Date of birth:_________________________

Phone: (home)____________________________ (cell)________________________

Email address: ____

Who referred you:_______________________________________ Why:______________________________________

When did symptoms begin?_________________________ Are symptoms: Improving/Staying the Same/Worsening

Have you received any previous treatment?____

Primary Care MD: ____

Other physicians currently participating in your care: ____

____

Do you have an advance directive/living will/power of attorney? Yes -- No

Have you fallen within the last 30 days? Yes -- No

Have you felt down, depressed or hopeless in the last 30 days: Yes – No

SOCIAL HISTORY: please circle the appropriate answer

Marital Status? Single Married Divorced Widowed

Do you use tobacco products? Never Current Former **# of packs/day** _____ **Age**: started ____ quit ____

Do you drink alcohol? Never Current Former **Type**: Beer Wine Liquor **How often**: _______________

Do you use recreational drugs? Never Current Former **Type**:________________ **Frequency**: _________

Employment: Working Retired Disabled **Type of work**: ____

Are you sexually active? Yes No

Do you currently participate in any exercise activity? Yes No

Home environment: Live alone _____ Live with ____

What type of diet do you currently follow: Regular Soft Liquid Diabetic Unable to eat

ALLERGIES: please list out any allergies to medications, food, or environment. Include side effects if known.

1.______________________________ 5.______________________________

2.______________________________ 6.______________________________

3.______________________________ 7.______________________________

4.______________________________ 8.______________________________

MEDICAL PROBLEMS: Example - asthma, cancer diabetes, heart disease, high blood pressure.

1.______________________________ 5.______________________________

2.______________________________ 6.______________________________

3.______________________________ 7.______________________________

4.______________________________ 8.______________________________

PAST SURGERIES: List any prior surgeries/procedures with date/year if known.

1.______________________________ 5.______________________________

2.______________________________ 6.______________________________

3.______________________________ 7.______________________________

4.______________________________ 8.______________________________

FAMILY HISTORY: Please indicate Y for Yes and N for No

Does any member of your family (immediate blood relative) have a history of/currently suffer from any of the following?:

	Y	N	Relative		Y	N	Relative
Breast Cancer	_____	_____	_________	Thyroid Cancer	_____	_____	_______________
Colon Cancer	_____	_____	_________	Esophageal Cancer	_____	_____	_______________
Lung Cancer	_____	_____	_________	Stomach Cancer	_____	_____	_______________
Pancreatic Cancer	_____	_____	_________	Liver Cancer	_____	_____	_______________
Melanoma	_____	_____	_________	Sarcoma	_____	_____	_______________
Other Cancer(s)	_____	_____	___________				

List other cancer(s):____

	Y	N	Relative		Y	N	Relative
Asthma	_____	_____	_________	Heart Disease	_____	_____	________________
Diabetes	_____	_____	_________	High blood Pressure	_____	_____	________________
Other Conditions	_____	_____	__________				

List other conditions:____

Unknown ______ Adopted _________

REVIEW OF SYSTEMS

Please indicate if you have experienced any of the following symptoms recently: **Circle** any that apply.

GENERAL:	Fevers, chills, weight loss, fatigue, loss of appetite
EYES, EARS, NOSE & THROAT:	Visual changes, double vision, ringing in ears, bleeding, ear/sinus infections
SKIN:	Rashes, changing moles, dryness, itching, sunburn
ENDOCRINE:	Intolerance to heat/cold, excessive thirst/hunger/urination
LUNGS:	Shortness of breath, cough, wheezing, blood in sputum
HEART:	Chest pain, irregular heartbeat, palpitations, chest pressure
GASTROINTESTINAL:	Abdominal pain, trouble swallowing, nausea, vomiting, diarrhea, constipation
GENITOURINARY:	Painful urination, blood in urine, frequent urination, incontinence
MUSCULOSKELETAL:	Muscle aches, back pain, joint pain, joint swelling
NEUROLOGICAL:	Headaches, numbness, weakness, memory loss, seizures, dizziness
PSYCHIATRIC:	Depression, anxiety, insomnia, mood changes
OTHER SYMPTOMS:	____

Any additional things you would like your physician to know: ____

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