Medical Intake Form

Name: _____

Date of Birth: _____

Sex/Gender/Pronouns: _____

Home Address: _____

_____

Telephone # (Home: H; Cell: C): _____

Email: _____

Preferred contact method/ Best time of day: _____

Emergency contacts: _____

Preferred hospital: _____

How you heard about us: _____

How do you consider your health status? _____

Allergies: Please list your medicine and other allergies as well as the side effect

_____

_____

Past Medical history: Please list medical conditions, past-current, treatment. Mark X below.

_____

_____

_____

General	**Joint/Musculoskeletal**	**Skin**
☐ Fatigue ☐ Fever ☐ Weight loss/gain >10lbs **Psychiatric** ☐ Depression/anxiety ☐ Suicidal thoughts ☐ Changes in sleep ☐ Hallucinations ☐ Trauma/Violence ☐ Loneliness	☐ Joint Pain ☐ Joint Inflammation ☐ Joint Redness ☐ Joint Stiffness ☐ Muscle Weakness ☐ Muscle pain/aches ☐ Decreased motion **Neck** ☐ Masses ☐ Neck pain ☐ Swollen Glands	☐ Easy Bruising ☐ Rash ☐ Skin lesions ☐ Itching **Breast** ☐ Breast pain/discharge ☐ Breast lump, dimpling ☐ Skin changes
Eye/Ear/Nose/Throat	**Pulmonary**	**Cardiovascular**
☐ Ear pain ☐ Hearing loss ☐ Hoarseness ☐ Nose bleeds ☐ Ringing in the ears ☐ Throat pain ☐ Vision changes ☐ Allergies	☐ Chronic cough ☐ Trouble breathing ☐ Shortness of breath ☐ Excess phlegm ☐ Wheezing ☐ Coughing up blood **Hematologic** ☐ Easy bleeding ☐ Enlarged lymph nodes ☐ Prolonged bleeding	☐ High/low blood pressure ☐ Palpitations ☐ Chest pain ☐ Swelling of the arms/legs ☐ Rapid/slow heart beat ☐ Leg pain with walking ☐ Varicose veins
Gastrointestinal	**Genitourinary**	**Endocrine**
☐ Abdominal pain ☐ Bloody or dark stools Rectal bleeding ☐ Constipation ☐ Diarrhea ☐ Nausea ☐ Vomiting ☐ Vomiting blood ☐ Trouble swallowing	☐ Blood in urine ☐ Trouble urinating ☐ Urinary Incontinence ☐ Kidney stones ☐ Urgency, frequency ☐ Painful urination ☐ Sexual dysfunction ☐ Menopausal symptoms ☐ Vaginal discharge	☐ Cold/hot intolerance ☐ Weight changes ☐ Appetite change ☐ Increased thirst ☐ Increased urination ☐ Hair changes
Neurological		
☐ Loss of bowel control/ Loss of bladder control ☐ Dizziness ☐ Headaches ☐ Numbness/tingling ☐ Passing out ☐ Tremors ☐ Seizures		

Individuals with menstrual cycles

Menstrual flow: Patten/length of cycle/age started/stopped: _____

_____

-First day of last period: _____

Are you pregnant currently/previous pregnancies: _____

_____

Birth control if applicable: _____

If applicable, last pap smear/history of abnormal pap: _____

If applicable, last mammogram/history of abnormal results: _____

Check any conditions you have or have had:

☐ Alcoholism	☐ Edema	☐ Multiple Sclerosis
☐ Anemia	☐ Emphysema	☐ Mumps
☐ Appendicitis	☐ Epilepsy	☐ Numbness/tingling
☐ Atherosclerosis	☐ Goiter	☐ Pace Maker/Defibrillator
☐ Asthma	☐ Gout	☐ Osteoporosis
☐ Bronchitis	☐ Heart burn	☐ Pneumonia
☐ Cancer	☐ Heart disease	☐ Polio
☐ Chicken Pox	☐ Hepatitis	☐ Rheumatic Fever
☐ Cold Sores	☐ Herpes	☐ Stroke/TIA
☐ Cystic Fibrosis	☐ High Cholesterol	☐ Thyroid Disease
☐ Diabetes	☐ HIV/AIDS	☐ Tuberculosis
☐ Dementia	☐ Influenza	☐ Ulcers
☐ Eczema	☐ Malaria	☐ Sexual Infections

Have been exposed to any type of trauma, social injustice, insecurity, discrimination?

_____

Past Surgical history: Please list all surgeries you have had, and the month and year completed.

_____

_____

Past hospitalizations: Please list all hospitalizations, which hospital, and dates it occurred.

_____

_____

Family History: Please list any medical issues your family members are being treated for.

Immediate Family:_____

_____

Extended Family: _____

Social History:

Occupation: _____

Nature of your job: _____

Do you stand/sit/lift heavy items/do repetitive movements: _____

For how long each day: _____

How long you have been at your job/enjoy work: _____

Do you enjoy work: _____

Relationship status: _____

Education/vocational training: _____

Living situation: _____

Pets: _____

Religion/Spirituality: _____

Daily activity, include hobbies: _____

How do you relax/enjoy yourself? _____

Travel (in/out of country/ever): _____

In the past 2 weeks have you felt:

Less interest or pleasure in doing things? _____

Down, depressed, or hopeless? _____

Habits:

Tobacco use (packs per day/years/ever): _____

Alcohol use (# per day/wk): _____

Illicit Substance use: _____

Sleep habits/total hours slept/mattress age/activity before bedtime: _____

_____

Exercise habits: min/day/wk/kind of activity: _____

_____

Diet/Food habits: give examples of the meals you have

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Soft drinks: _____

Caffeine: _____

Sugar: _____

Water: _____

Salty food: _____

Medications: Please list your meds, supplements, dosage, how often you take it, and indication

_____

_____

_____

Please check which vaccinations you have received:

☐ Measles, Mumps & Rubella Vaccine ☐ Varicella/Zoster-Shingles Vaccine

☐ Chicken Pox Vaccine ☐ Hepatitis B Vaccine ☐ Pneumococcal Vaccine

☐ Influenza Vaccine ☐ Tetanus ☐ Human Papilloma Virus

Last time you went to a doctor: _____

What would you like to change or improve with your health over time?

_____

What medical concerns do you have currently? Please list in order of importance.

_____

You agree that you have answered the above to the best of your knowledge.

Name/Signature: _____

Date: _____