Name: _____ DOB:_____

PATIENT MEDICAL INTAKE FORM

PATIENT HISTORY

What is the REASON for the office visit? _____

Who referred you to our office/ How did you hear about us?_____

CURRENT MEDICATIONS: Are you taking any medications now? O **Yes** O **No**
If yes, please list **name/dosage/frequency/route** of the medicine. Include prescription, over the counter, natural, herbals:

Name of Medicine	Dosage	Frequency	Route	Prescribing physician/date

ALLERGIES: Are you allergic to any ***MEDICATIONS***? O **Yes** O **No**
If yes, please **list** the **medication(s)** and **reaction**?
Medication:_____Reaction:_____
Medication:_____Reaction:_____
Medication:_____Reaction:_____

SURGERIES: Have you ever had surgery(ies)? O **Yes** O **No** If yes, please state **type/date** below

Date of Surgery (approximate date)	**Type of Surgery**

Have you ever been ***HOSPITALIZED?*** O **Yes** O **No** O **For Above Surgery(ies)**
If yes, please state **cause** and **when?**_____

Have you ever had an ***ALLERGY TEST***? O **Yes** O **No** O **I don't know**
If yes, please state **where** and **when?** _____Date:___/____/___

Have you ever had a ***HEARING TEST***? O **Yes** O **No** O **I don't know**
If yes, please state **when** and **where**? _____
Did it show a hearing loss? O **Yes** O **No** O **I don't know**

If female, are you (or could you be) ***PREGNANT***? O **Yes** O **No**

Name: _____ DOB:_____

Please fill in each appropriate circle (O) completely: example ● (Do not mark with X)

PAST MEDICAL HISTORY:

Have you ever been diagnosed with any of the following? If yes, please **mark** the following:

O Acid Reflux	O COPD/Emphysema	O Hearing Loss	O Hives
O Allergic Rhinitis	O Depression	O Heart Attack	O Immunodeficiency
O Anxiety Disorder	O Deviated Septum	O Heart Disease What type?	O Sleep Apnea
O Asthma	O Diabetes	O Hepatitis	O Thyroid Disease
O Bleeding Disorder	O Ear Infections	O High Blood Pressure	O TMJ Disease
O Cancer What type? _____	O Eczema	O High Cholesterol	O Tonsillitis
O Chronic Sinusitis	O Headaches	O HIV/AIDS	

O Other: _____

O Other: _____

FAMILY HISTORY

Father:	O Alive	O Deceased	O Healthy	Medical problems: O Diabetes O High Blood Pressure O Stroke O Heart Attack O Mental Illness O Cancer
Mother:	O Alive	O Deceased	O Healthy	Medical problems: O Diabetes O High Blood Pressure O Stroke O Heart Attack O Mental Illness O Cancer

# of Son(s):	O None O 1 O 2 O 3 O 4 O 5	#Daughter(s):	O None O 1 O 2 O 3 O 4 O 5
#Brothers(s):	O None O 1 O 2 O 3 O 4 O 5	# of Sister(s)	O None O 1 O 2 O 3 O 4 O 5

SOCIAL HISTORY

OCCUPATION: What is your occupation? _____

O **Full-time** O **Part-time** O **Student** O **Not employed** O **Retired**

CAFFEINE: Do you drink caffeine? O **Yes** O **No** **Cups per day?** O 1 or less O 2-4 O >4

PETS: Do you have pets in the home? O **Yes** O **No** O Dog O Cat O Bird O Other:

SMOKING: Do you smoke cigarettes? O **Yes** O **No # Packs/day?** O 1/2pk O 1pk O >1-2pks

CHEWING TOBACCO: Do you chew tobacco? O **Yes** O **No**

ALCOHOL: Do you consume alcohol? O **Yes** O **No Drinks per week?** O 1 or less O 2-4 O >4

DRUGS: Do you use any recreational drugs? O **Yes** O **No** **List:**

HOBBIES: Are you active with hobbies? O **Yes** O **No** **Type of hobby?**

EXERCISE: Do you exercise? O **Yes** O **No** **How often?** O Once a wk O 2-4d/wk O >5d/wk

HOME LIVING SITUATION? O **Alone** O **w/ Spouse** O **w/Spouse & Kids** O **w/Kids** O **Other:**_____

Name: _____ DOB:_____

PATIENT REVIEW OF SYSTEMS						
Please indicate if you've had any of the below symptoms: ***Please fill in each appropriate circle (O) <u>completely</u>: example ● (Do not mark with X)***						
Allergy	Medication:	Yes O	No O	Bee Venom:	Yes O	No O
	Pollens:	Yes O	No O	Vaccination:	Yes O	No O
	Foods:	Yes O	No O	Latex:	Yes O	No O
Cardiology	Catherization:	Yes O	No O	High Blood Pressure:	Yes O	No O
	Chest Pain:	Yes O	No O	High Cholesterol:	Yes O	No O
	Bypass surgery:	Yes O	No O	Blood thinners:	Yes O	No O
	Palpitations:	Yes O	No O			
Dermatology	Hives:	Yes O	No O	Eczema/Itchy skin:	Yes O	No O
	Rash:	Yes O	No O			
Endocrine	Weight Gain/Loss:	Yes O	No O	Cold/Heat Intolerance:	Yes O	No O
				Insomnia:	Yes O	No O
ENT	Nose bleeds:	Yes O	No O	Sinus pain:	Yes O	No O
	Voice Change:	Yes O	No O	Hearing loss:	Yes O	No O
	Cough:	Yes O	No O	Nasal congestion:	Yes O	No O
	Ringing in ears:	Yes O	No O	Sore throat:	Yes O	No O
Gastrointestinal	Constipation:	Yes O	No O	Nausea:	Yes O	No O
	Diarrhea:	Yes O	No O	Abdominal Pain:	Yes O	No O
	Heartburn:	Yes O	No O	Difficulty swallowing:	Yes O	No O
	Vomiting:	Yes O	No O			
Musculoskeletal	Carpal tunnel:	Yes O	No O	Back pain:	Yes O	No O
	Neck pain:	Yes O	No O	Joint pain:	Yes O	No O
Neurological	Headache:	Yes O	No O	Stroke:	Yes O	No O
	Seizures:	Yes O	No O	Insomnia:	Yes O	No O
	Tingling/numbness:	Yes O	No O			
Psychiatric	Depression:	Yes O	No O	Mood swings:	Yes O	No O
	Anxiety:	Yes O	No O	High stress level:	Yes O	No O
Respiratory	Chest Tightness:	Yes O	No O	Shortness of Breath:	Yes O	No O
	Wheezing:	Yes O	No O			