

Patient History Intake (PS)

Today's Date: _____

Patient Name: _____

Birth Date: _____

Age: _____

Important: In order to provide the highest quality of health care possible, it is important that we have the following information. Please answer all of the doctor's questions as accurately as possible. If you do not understand the question please ask for assistance. Thank you.

Please describe the reason(s) for this visit: _____

Review of Systems:

Do you have now or have you had within the past year:

Const	Weight Gain/Lossno yes	CV	Chest painno yes	Psych	Depressionno yes
	Fever.....no yes		Rapid heart beatno yes		Mood swingsno yes
	Fatigue.....no yes		Swollen hands/feet....no yes		Sleep Disturbancesno yes
Eyes	Dry eyesno yes	Skin	Skin rashno yes	Neuro	Seizuresno yes
	Vision changesno yes		Painful breasts.....no yes		Frequent headaches ..no yes
ENT	Mouth soresno yes		Breast lumps.....no yes		Dizzinessno yes
	Sore throat.....no yes		Nipple dischargeno yes		Numbnessno yes
	Ringling in earsno yes	GI	Persistent diarrheano yes	MSK	Joint or muscle painno yes
	Sinus headachesno yes		Bloody stoolsno yes		Muscle weaknessno yes
Resp	Persistent coughno yes		Nausea, vomiting.....no yes	Lymph	Swollen lymph nodes ...no yes
	Coughing blood.....no yes		Constipationno yes	Heme	Easy bleedingno yes
	Wheezing.....no yes		Bloating/gas.....no yes		Easy bruisingno yes
	Shortness of breath....no yes		Abdominal painno yes	Endo	Night sweats.....no yes
CV	Shortness of breath	ALL	Hives, blistersno yes		Hot/cold intolerance ...no yes
	with activity.....no yes		Red, itchy eyes.....no yes	Other	_____
	Difficulty breathing		Persistent sore throat .no yes		_____
	lying down.....no yes				_____

For female patients only:

Age period began _____

Number of pregnancies _____

Date of last mammogram _____

Did you breast feed? no yes

Do you do regular breast self-examinations?

Breast lump or discharge no yes

Drug allergies: _____

List any medications you are taking, including non-prescription drugs, vitamins, and herbals: _____

Past Medical History:

Have you ever had the following:

Heart diseaseno yes	Cancerno yes	Stomach Ulcerno yes
Arthritisno yes	Glaucomano yes	Kidney diseaseno yes
Rheumatic Feverno yes	Asthmano yes	Thyroid Diseaseno yes
Anemiano yes	AIDS or HIV+no yes	Bleeding tendencyno yes
Tuberculosisno yes	Strokeno yes	Mitral Valve Prolapseno yes
Diabetesno yes	Hepatitisno yes	High Blood Pressureno yes
Allergies.....no yes		

List any other surgeries or major illnesses and dates: _____

Family History:

Has any blood relative ever had the following:

Breast Cancer	no	yes	High blood pressure .	no	yes	Kidney disease	no	yes
Melanoma	no	yes	Heart Disease	no	yes	Depression	no	yes
Stroke	no	yes	Diabetes	no	yes			

Social History:

Occupation: _____

Smoking (type & amount per day)_____

Alcohol (type and amount per week)_____

If former smoker, date quit:_____

Weight_____Height_____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

X _____
Signature of patient or parent if minor

Date