



**PATIENT INTAKE HISTORY (Continued)**

PATIENT NAME:	BIRTH DATE: / /	MR#:	AGE:	DATE: / /
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**OBSTETRIC HISTORY**

PREGNANCIES	NUMBER	ABORTIONS	NUMBER	MISCARRIAGES	NUMBER	
PREMATURE BIRTHS (<37 WEEKS)		LIVE BIRTHS		LIVING CHILDREN		
<b>NO.</b>	<b>BIRTH DATE</b>	<b>WEIGHT AT BIRTH</b>	<b>BABY'S SEX</b>	<b>WEEKS PREGNANT</b>	<b>TYPE OF DELIVERY (VAGINAL , CESAREAN, ETC.)</b>	<b>COMPLICATIONS?</b>
1						
2						
3						
4						
HAVE YOU EVER HAD AN ECTOPIC PREGNANCY?						
HAVE YOU EVER HAD DIFFICULTY CONCEIVING?						
<b>PHYSICIAN'S NOTES</b>						

**CURRENT MEDICATIONS**

(INCLUDING HORMONES, VITAMINS, HERBS, NONPRESCRIPTION MEDICATIONS)

DRUG NAME	DOSAGE	WHO PRESCRIBED	DRUG NAME	DOSAGE	WHO PRESCRIBED

**FAMILY HISTORY**

MOTHER: <input type="checkbox"/> LIVING <input type="checkbox"/> DECEASED - CAUSE:		AGE:	FATHER: <input type="checkbox"/> LIVING <input type="checkbox"/> DECEASED - CAUSE:		AGE:
SIBLINGS: NUMBER LIVING		NUMBER DECEASED:	CAUSE(S)/AGE(S):		
CHILDREN: NUMBER LIVING		NUMBER DECEASED:	CAUSE(S)/AGE(S):		
ILLNESS	YES	WHICH RELATIVE AND AGE OF ONSET	PHYSICIAN'S NOTES		
DIABETES	<input type="checkbox"/>				
STROKE	<input type="checkbox"/>				
HEART DISEASE	<input type="checkbox"/>				
BLOOD CLOTS IN LUNGS OR LEGS	<input type="checkbox"/>				
HIGH BLOOD PRESSURE	<input type="checkbox"/>				
HIGH CHOLESTEROL	<input type="checkbox"/>				
OSTEOPOROSIS (WEAK BONES)	<input type="checkbox"/>				
HEPATITIS	<input type="checkbox"/>				
HIV/AIDS	<input type="checkbox"/>				
TUBERCULOSIS	<input type="checkbox"/>				
BIRTH DEFECTS	<input type="checkbox"/>				
DRINKING OR DRUG PROBLEM	<input type="checkbox"/>				
BREAST CANCER	<input type="checkbox"/>				
COLON CANCER	<input type="checkbox"/>				
OVARIAN CANCER	<input type="checkbox"/>				
UTERINE CANCER	<input type="checkbox"/>				
MENTAL ILLNESS/DEPRESSION	<input type="checkbox"/>				
ALZHEIMER'S DISEASE	<input type="checkbox"/>				
ANESTHETIC COMPLICATIONS?	<input type="checkbox"/>				

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### SOCIAL HISTORY

	YES	NO	
EVER SMOKED? CURRENT SMOKING : PACKS PER DAY YEARS:	<input type="checkbox"/>	<input type="checkbox"/>	
ALCOHOL: DRINKS PER DAY: DRINKS PER WEEK:	<input type="checkbox"/>	<input type="checkbox"/>	
RECREATIONAL DRUG USE:	<input type="checkbox"/>	<input type="checkbox"/>	
SEAT BELT USE	<input type="checkbox"/>	<input type="checkbox"/>	
REGULAR EXERCISE: H OW LONG AND HOW OFTEN?	<input type="checkbox"/>	<input type="checkbox"/>	
DAIRY PRODUCT INTAKE/CALCIUM SUPPLEMENTS: QUANTITY	<input type="checkbox"/>	<input type="checkbox"/>	
HEALTH HAZARDS AT HOME OR WORK?	<input type="checkbox"/>	<input type="checkbox"/>	
HAVE YOU BEEN SEXUALLY ABUSED, THREATENED, OR HURT BY ANYONE?	<input type="checkbox"/>	<input type="checkbox"/>	

### PERSONAL PROFILE

SEXUAL ORIENTATION: <input type="checkbox"/> HETEROSEXUAL <input type="checkbox"/> HOMOSEXUAL <input type="checkbox"/> BISEXUAL
MARITAL STATUS: <input type="checkbox"/> MARRIED <input type="checkbox"/> LIVING WITH PARTNER <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
NUMBER OF LIVING CHILDREN:
HOBBIES?
SCHOOL COMPLETED: <input type="checkbox"/> HIGH SCHOOL <input type="checkbox"/> SOME COLLEGE/AA DEGREE <input type="checkbox"/> COLLEGE <input type="checkbox"/> GRADUATE DEGREE <input type="checkbox"/> OTHER
CURRENT OR MOST RECENT JOB?
TRAVEL OUTSIDE THE U.S.? _____ LOCATION? _____

### PERSONAL PAST HISTORY OF ILLNESSES

MAJOR ILLNESSES	YES (DATE)	NO	NOT SURE	
ASTHMA				
PNEUMONIA/LUNG DISEASE				
KIDNEY INFECTIONS/STONES				
TUBERCULOSIS				
SEXUALLY TRANSMITTED DISEASE				
HIV/AIDS				
HEART ATTACK/PROBLEMS				
DIABETES				
HIGH BLOOD PRESSURE				
STROKE				
RHEUMATIC FEVER				
BLOOD CLOTS IN LUNGS OR LEGS				
EATING DISORDERS				
COLLAGEN VASCULAR DISEASE (LUPUS)				
CHICKENPOX				
CANCER				
REFLUX/HIATAL HERNIA/ULCERS				
DEPRESSION/ANXIETY				
ANEMIA				
BLOOD TRANSFUSIONS				
SEIZURES/CONVULSIONS/EPILEPSY				
BOWEL PROBLEMS				
GLAUCOMA				
CATARACTS				
ARTHRITIS/JOINT PAIN/BACK PROBLEMS				
BROKEN BONES				
HEPATITUS/YELLOW JAUNDICE/LIVER DISEASE				
THYROID DISEASE				

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**PERSONAL PAST HISTORY OF ILLNESSES**

MAJOR ILLNESSES	YES (DATE)	NO	NOT SURE	PHYSICIAN'S NOTES
GALLBLADDER DISEASE				
HEADACHES				
OTHER				

**OPERATIONS/HOSPITALIZATIONS**

REASON	DATE	HOSPITAL

**INJURIES/ILLNESSES**

TYPE	DATE	TYPE	DATE

**IMMUNIZATION/TEST**

	DATE		DATE
TETANUS-DIPHTHERIA BOOSTER		INFLUENZA VACCINE (FLU SHOT)	
HEPATITIS A VACCINE		HEPATITIS B VACCINE	
VARICELLA VACCINE		PNEUMOCOCCAL VACCINE	
MEASLES-MUMPS-RUBELLA (MMR) VACCINE		TUBERCULOSIS (TB) SKIN TEST	

HPV IMMUNIZATION (GARDASIL) ?	WHEN?
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<b>PHYSICIAN NOTES:</b>

**REVIEW OF SYSTEMS**

Please check (x) if any of the following symptoms apply to you now or since adulthood

	NOW	PAST	NOT SURE	PHYSICIAN'S NOTES
<b>1. CONSTITUTIONAL</b>				
WEIGHT LOSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
WEIGHT GAIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
FEVER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
FATIGUE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CHANGE IN HEIGHT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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### REVIEW OF SYSTEMS (CONTINUED)

	NOW	PAST	NOT SURE	PHYSICIAN'S NOTES
<b>2. EYES</b>				
DOUBLE VISION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SPOTS BEFORE EYES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
VISION CHANGES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
GLASSES/CONTACTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3. EAR, NOSE AND THROAT</b>				
EARACHES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
RINGING IN EARS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HEARING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SINUS PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SORE THROAT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MOUTH SORES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DENTAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>4. CARDIOVASCULAR</b>				
PAINFUL BREATHING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CHEST PAIN OR PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DIFFICULTY BREATHING ON EXERTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SWELLING OF LEGS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
RAPID OR IRREGULAR HEARTBEAT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>5. RESPIRATORY</b>				
WHEEZING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SPITTING IP BLOOD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SHORTNESS OF BREATH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CHRONIC COUGH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>6. GASTROINTESTINAL</b>				
FREQUENT DIARRHEA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
BLOODY STOOL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NAUSEA/VOMITING/INDIGESTION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CONSTIPATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
INVOLUNTARY LOSS OF GAS OR STOOL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>7. GENITOURINARY</b>				
BLOOD IN URINE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PAIN WITH URINATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
STRONG URGENCY TO URINATE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
FREQUENT URINATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
INCOMPLETE EMPTYING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
INVOLUNTARY/UNINTENDED URINE LOSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
URINE LOSS WHEN COUGHING OR LIFTING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ABNORMAL BLEEDING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PAINFUL PERIODS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PREMENSTRUAL SYNDROME (PMS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PAINFUL INTERCOURSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
FIBROIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
INFERTILITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DES EXPOSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ABNORMAL VAGINAL DISCHARGE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>8. MUSCULOSKELETAL</b>				
MUSCLE WEAKNESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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### REVIEW OF SYSTEMS (CONTINUED)

	NOW	PAST	NOT SURE	PHYSICIAN'S NOTES
<b>8. MUSCULOSKELETAL (continued)</b>				
MUSCLE OR JOINT PAIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>9a. SKIN</b>				
RASH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SORES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DRY SKIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MOLES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>9b. BREASTS</b>				
PAIN IN BREAST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NIPPLE DISCHARGE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
LUMPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>10. NEUROLOGIC</b>				
DIZZINESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NUMBNESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
TROUBLE WALKING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SEVERE MEMORY PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
FREQUENT OR SEVERE HEADACHES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>11. PSYCHIATRIC</b>				
DEPRESSION OR FREQUENT CRYING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SEVERE ANXIETY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>12. ENDOCRINE</b>				
HAIR LOSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HEAT/COLD TOLERANCE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ABNORMAL THIRST	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HOT FLASHES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>13. HEMATOLOGIC/LYMPHATIC</b>				
FREQUENT BRUISES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CUTS DO NOT STOP BLEEDING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ENLARGED LYMPH NODES (GLANDS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>14. ALLERGIC/IMMUNOLOGIC</b>				
MEDICATION ALLERGIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
IF ANY, PLEASE LIST ALLERGY AND TYPE OF REACTION:				
OTHER ALLERGIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PLEASE LIST ALLERGY AND TYPE OF REACTION				

FORM COMPLETED BY:  PATIENT  OFFICE NURSE  PHYSICIAN  OTHER (PLEASE LIST WHO):

SIGNATURE OF PATIENT:

DATE REVIEWED BY PHYSICIAN WITH PATIENT: / /

PHYSICIAN SIGNATURE:

**ANNUAL REVIEW OF HISTORY**

DATE REVIEWED: / /

PHYSICIAN SIGNATURE:

DATE REVIEWED: / /

PHYSICIAN SIGNATURE:

DATE REVIEWED: / /

PHYSICIAN SIGNATURE:

DATE REVIEWED: / /

PHYSICIAN SIGNATURE: