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Plano, TX 75093
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214-239-1641

Patient Intake Form- Adult

Date: ______________________

PATIENT INFORMATION

Last Name ____________________ First Name ________________ M.I. _____ Date of Birth ___/___/_____

Age ____ Sex ____ SSN : ________________ Race ______________ Ethnicity ___Hispanic ____Not Hispanic

Address __________________________ Apt # _____ City ________________ State _______ Zip ______

Email Address _____________________________________ Preferred Language _____________________

Home Phone __________________ Cell Phone __________________ Work Phone ____________________

How may our office best contact you? (check one) ____Home Phone ____Cell Phone ____Work Phone

Preferred method of appointment reminder? ____Text ____Phone (circle: cell or home)

Occupation ________________________________ Employer _________________________________

PHARMACY

Pharmacy Name ________________________________ Phone __________________ Fax _______________

Address ____ City/State/Zip ____________________________

INSURANCE INFORMATION

Primary Insurance Carrier _______________________

ID# _____ __________________________________

Group # ____________________________________

Subscriber Name _____________________________

Subscriber SS # ______________________________

Subscriber Birth Date __________________________

Relationship to Patient _________________________

Employer ___________________________________

Secondary Insurance Carrier ______________________

ID# ______________________________________

Group # ___________________________________

Subscriber Name ____________________________

Subscriber SS# ______________________________

Subscriber Birth Date _________________________

Relationship to Patient ________________________

Employer __________________________________

REFERRING PHYSICIAN

Physician Name _________________________ Practice Phone ______________________________

May we thank someone else (non-physician) for referring you to our office? __________________________

ALLERGY INFORMATION

Drug Allergies ______________________________ Environmental Allergies _______________________________

Are you allergic to latex? ____ Yes ____ No Are you allergic to medical tape? ____ Yes ____ No

Patient Name: ____ Date of Birth: _______________

SOCIAL HISTORY

Exercise: Yes _____No_____ How often: Daily______2-3x a week________3-4x a week________

Use Alcohol: Never______1 a month______2-4 a month______2-3 a week______4+ a week ____Number in one occasion______

How often did you have 6+ drinks on one occasion in the past year: Never______ Monthly_____ Weekly_______ Daily _______

Do you CURRENTLY smoke or use tobacco products: Yes___ No ___What do you use________ How often ____Daily ____Occ.

Have you EVER smoked or used tobacco products: Yes_____ No_____ How often did you use: Everyday____ Occasionally_____

How much ____________ How many years _________When did you quit __________What did you use ____________________

Have you used drugs in the last 12 months (Marijuana/Heroin/LSD/Cocaine/Other) Yes________ No________

MEDICATION

Please list all medications you are currently taking including over the counter medications, herbals, etc.

____ No Current Medications

Medication__________________ Reason for Taking _______________Medication_________________ Reason _______________

Medication__________________ Reason for Taking _______________Medication _________________Reason_______________

Medication__________________ Reason for Taking _______________Medication _________________Reason _______________

HEALTH HISTORY

What problems are you here for today? ____

Do you currently have or frequently experience:

____Alcoholism	____Cancer	____Heart Failure	____Mental Illness
____Anemia	____Depression	____Hepatitis	____Reflux
____Arthritis	____Diabetes	____High Blood Pressure	____Sleep Apnea
____Atrial Fibrillation	____Emphysema	____High Cholesterol	____ Stroke
____Asthma	____Epilepsy/Seizures	____HIV/AIDS	____ Thyroid Problem
____Birth Defects	____Glaucoma	____Kidney Disease	____ Tuberculosis
____Bladder Disease	____Headaches	____Liver Problem	____Weight Loss/Gain
____Bleeding Disorder	____Heart Attack	____Lung Problem	____Other:__________________

Have you undergone any of the following surgeries?

Tonsillectomy	Date:____________________	Adenoidectomy	Date:______________________
Ear Surgery	Date:____________________	Thyroid Surgery	Date:______________________
Ear Tubes	Date:____________________	Nasal/Sinus Surgery	Date:______________________

Other: ____

FAMILY HISTORY

Has anyone in your family had: M=Mother, F=Father, S=Sibling, MGM= Maternal Grandmother, MGF= Maternal Grandfather, PGM= Paternal Grandmother, or PGF= Paternal Grandfather

____Alcoholism	____Cancer	____Heart Failure	____Mental Illness
____Anemia	____Depression	____Hepatitis	____Reflux
____Arthritis	____Diabetes	____High Blood Pressure	____Sleep Apnea
____Atrial Fibrillation	____Emphysema	____High Cholesterol	____ Stroke
____Asthma	____Epilepsy/Seizures	____HIV/AIDS	____ Thyroid Problem
____Birth Defects	____Glaucoma	____Kidney Disease	____ Tuberculosis
____Bladder Disease	____Headaches	____Liver Problem	____Weight Loss/Gain
____Bleeding Disorder	____Heart Attack	____Lung Problem	____Other:__________________

Patient Name:____ Date of Birth: ________________

PATIENT REVIEW OF SYSTEMS

Do you consider yourself generally: ________Healthy ________Change in appetite __________ Fever __________
Do you frequently have or frequently experience: (Please check ALL that apply)

Allergy/Immunologic ____**None** ____Reactions ____Sneezing ____Eye Irritation ____Other:____________________

Eyes ____**None** ____Irritation from light ____ Blurred Vision ____Other____________

Ears, Nose, Throat & Mouth ____**None** ____Itching Nose ____Rhinitis ____ Bruxism (teeth grind) ____Nose Blocked ____Sores in Mouth ____Post Nasal Drip ____Teeth Hurt ____Painful Swallowing ____Pressure in Ear ____Hearing Loss ____Difficulty Swallowing

Respiratory (Lungs) ____**None** ____Cough ____Shortness of Breath while sitting ____Wheezing ____Other:__________________________

Cardiovascular (Heart) ____**None** ____Cyanosis ____Palpitations/Fluttering of Heart ____ Pain in Chest ____Shortness of Breath while exercising

Gastrointestinal ____**None** ____Pain ____Constipation ____Diarrhea ____Indigestion ____Other:____________________________

Hematologic/Lymph Nodes ____**None** ____Bleeding Easily ____Night sweats ____Other:__________

Genitourinary ____**None** ____Hesitation when urinating ____Urination at Night ____Pain when urinating ____Other:__________

Musculoskeletal ____**None** ____Cramping ____Soreness ____Weakness ____Other:______________________________________

Integumentary ____**None** ____Dry Skin ____Itchy Skin ____Lesions on Skin ____Bleeding ____Other:________________

Neurological (Nerves) ____**None** ____ Dizziness/Vertigo ____Ringing in Ears ____Abnormal Movements ____Twitch ____Other:__________________________

Psychiatric ____**None** ____Situational Stress ____Depression ____Mood Swings ____Anxiety ____Other:__________________________

Endocrine ____**None** ____Hot Flashes ____Hair Loss/Growth ____Heat ____Cold ____Other:__________________________

Patient Comments: ____

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Signature of Patient/Guardian ______________________**Date**________________