

Patient Intake Form- Adult

Date: _____

PATIENT INFORMATION

Last Name _____ First Name _____ M.I. _____ Date of Birth ____/____/____
Age ____ Sex ____ Race _____ Ethnicity ____ Hispanic ____ Not Hispanic Preferred Language _____
Address _____ Apt # _____ City _____ State _____ Zip _____
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)
Email Address: _____ Occupation _____
Emergency contact: _____ Phone: _____

PHARMACY

Pharmacy Name _____ Phone _____ Fax _____
Address _____ City/State/Zip _____

INSURANCE INFORMATION

Primary Insurance Carrier _____	Secondary Insurance Carrier _____
ID# _____	ID# _____
Group # _____	Group # _____
Subscriber Name _____	Subscriber Name _____
Subscriber Birth Date _____	Subscriber Birth Date _____
Relationship to Patient _____	Relationship to Patient _____

REFERRING PHYSICIAN

Referring Physician Name _____ Practice Phone _____
Primary Care Physician _____ 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

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 ____

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MEDICATION

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

___ No Current Medications

Medication _____ Reason _____

Medication _____ Reason _____

Medication _____ Reason _____

Medication _____ Reason _____

Medication _____ Reason _____

Medication _____ Reason _____

Medication _____ Reason _____

Medication _____ Reason _____

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: _____

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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	<input type="checkbox"/> None	<input type="checkbox"/> Reactions	<input type="checkbox"/> Sneezing	<input type="checkbox"/> Eye Irritation
		<input type="checkbox"/> Other: _____		
Eyes	<input type="checkbox"/> None	<input type="checkbox"/> Irritation from light	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Other _____
Ears, Nose, Throat & Mouth	<input type="checkbox"/> None	<input type="checkbox"/> Itching Nose	<input type="checkbox"/> Rhinitis	<input type="checkbox"/> Bruxism (teeth grind)
		<input type="checkbox"/> Nose Blocked	<input type="checkbox"/> Sores in Mouth	<input type="checkbox"/> Post Nasal Drip
		<input type="checkbox"/> Teeth Hurt	<input type="checkbox"/> Painful Swallowing	<input type="checkbox"/> Pressure in Ear
		<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Difficulty Swallowing	
Respiratory (Lungs)	<input type="checkbox"/> None	<input type="checkbox"/> Cough	<input type="checkbox"/> Shortness of Breath while sitting	
		<input type="checkbox"/> Wheezing	<input type="checkbox"/> Other: _____	
Cardiovascular (Heart)	<input type="checkbox"/> None	<input type="checkbox"/> Cyanosis	<input type="checkbox"/> Palpitations/Fluttering of Heart	
		<input type="checkbox"/> Pain in Chest	<input type="checkbox"/> Shortness of Breath while exercising	
Gastrointestinal	<input type="checkbox"/> None	<input type="checkbox"/> Pain	<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea
		<input type="checkbox"/> Indigestion	<input type="checkbox"/> Other: _____	
Hematologic/Lymph Nodes	<input type="checkbox"/> None	<input type="checkbox"/> Bleeding Easily	<input type="checkbox"/> Night sweats	<input type="checkbox"/> Other: _____
Genitourinary	<input type="checkbox"/> None	<input type="checkbox"/> Hesitation when urinating	<input type="checkbox"/> Urination at Night	
		<input type="checkbox"/> Pain when urinating	<input type="checkbox"/> Other: _____	
Musculoskeletal	<input type="checkbox"/> None	<input type="checkbox"/> Cramping	<input type="checkbox"/> Soreness	<input type="checkbox"/> Weakness
		<input type="checkbox"/> Other: _____		
Integumentary	<input type="checkbox"/> None	<input type="checkbox"/> Dry Skin	<input type="checkbox"/> Itchy Skin	<input type="checkbox"/> Lesions on Skin
		<input type="checkbox"/> Bleeding	<input type="checkbox"/> Other: _____	
Neurological (Nerves)	<input type="checkbox"/> None	<input type="checkbox"/> Dizziness/Vertigo	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Abnormal Movements
		<input type="checkbox"/> Twitch	<input type="checkbox"/> Other: _____	
Psychiatric	<input type="checkbox"/> None	<input type="checkbox"/> Situational Stress	<input type="checkbox"/> Depression	<input type="checkbox"/> Mood Swings
		<input type="checkbox"/> Anxiety	<input type="checkbox"/> Other: _____	
Endocrine	<input type="checkbox"/> None	<input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Hair Loss/Growth	<input type="checkbox"/> Heat
		<input type="checkbox"/> Cold	<input type="checkbox"/> Other: _____	

Patient Comments: _____

Signature of Patient/Guardian _____ Date _____