Dr. Rohn and Dr. Gamble
6300 W Parker Rd Suite G24
Plano, TX 75093
972-378-0633

7515 Greenville Ave Suite 410
Dallas, TX 75231
214-239-1641

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 ______________________________

ID# ______ ____

Group # ____

Subscriber Name _____________________________________

Subscriber Birth Date __________________________________

Relationship to Patient _________________________________

Secondary Insurance Carrier ____________________________

ID# ____

Group # ____

Subscriber Name _____________________________________

Subscriber Birth Date __________________________________

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________

Patient Name: ______________________________ Date of Birth: ______________

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:______________

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**______________________