

Patient History Intake Form

Patient Name: _____

DOB: _____

Primary Care Doctor: _____

Other Doctors: _____

Referred By: _____

Primary Care Doctor:

Specialist:

ER Doctor:

Self Referred:

Main Reason for Today's Visit:

Shortness of Breath
 Palpitations
 Chest Pain
 Dizziness/Fainting
 Arm/Jaw Pain

Swelling
 Abnormal EKG
 Atrial Fib
 Pre-Op Clearance
 Other

General

Tobacco (circle all that apply)
 Cigarettes, Cigars,
 Pipes, Chew

Currently Use: Yes No
 Amount (per day): _____

Former Use: Yes No

	Yes No	Yes No
Diabetes	<input type="checkbox"/> <input type="checkbox"/>	Leg Pain/Cramps <input type="checkbox"/> <input type="checkbox"/>
Hypertension	<input type="checkbox"/> <input type="checkbox"/>	History of DVT <input type="checkbox"/> <input type="checkbox"/>
High Cholesterol	<input type="checkbox"/> <input type="checkbox"/>	(Clotting in Legs)
		Claudication/ <input type="checkbox"/> <input type="checkbox"/>

Family Heart Disease:
 If Yes:
 Mother (Age when diagnosed) _____
 Father (Age when diagnosed) _____
 Siblings (Age when diagnosed) _____

Have you ever had: Yes No
 Stress Tests

Have you ever had: Yes No
 Heart Attack

If Yes, When _____
 Treatment _____

Coronary Disease
 Stent

Bypass Surgery
 Murmur
 Leaky Valve
 Rheumatic Fever
 Valve Surgery

If Yes, Please Mark Type of Valve:
 Porcine Bovine Mechanical

Aortic Mitral
 Pacemaker

Brand _____
 Defibrillator

Brand _____
 Swelling

Peripheral Vascular Disease

Stroke/Mini Stroke
 If Yes, did you experience:

Unusual Headache Numbness/Tingling
 Left or Right Weakness Paralysis
 Speaking problem
 Partial Blindness
 Double Vision

Seizures

Hearing Problems
 If Yes, which ear: Right Ear Left Ear

Nasal Problems
 Oral Problems
 Swallowing Difficulty
 Ringing in the Ears
 Thyroid Problems

	Yes No	Yes No
Weight Gain	<input type="checkbox"/> <input type="checkbox"/>	Weight Loss <input type="checkbox"/> <input type="checkbox"/>
Fever	<input type="checkbox"/> <input type="checkbox"/>	

	Yes No	Yes No
Glaucoma	<input type="checkbox"/> <input type="checkbox"/>	Cataracts <input type="checkbox"/> <input type="checkbox"/>
Retina Problems	<input type="checkbox"/> <input type="checkbox"/>	

	Yes No	Yes No
Asthma <input type="checkbox"/> <input type="checkbox"/>	Vomiting Blood <input type="checkbox"/> <input type="checkbox"/>	Yellow Jaundice <input type="checkbox"/> <input type="checkbox"/>
Emphysema <input type="checkbox"/> <input type="checkbox"/>	Black Stools <input type="checkbox"/> <input type="checkbox"/>	Gallstones <input type="checkbox"/> <input type="checkbox"/>
Pneumonia <input type="checkbox"/> <input type="checkbox"/>	Bloody Stools <input type="checkbox"/> <input type="checkbox"/>	Hepatitis <input type="checkbox"/> <input type="checkbox"/>
Wheezing <input type="checkbox"/> <input type="checkbox"/>	Bright Red Blood <input type="checkbox"/> <input type="checkbox"/>	Pancreas Trouble <input type="checkbox"/> <input type="checkbox"/>
Coughing up Blood <input type="checkbox"/> <input type="checkbox"/>	per Rectum <input type="checkbox"/> <input type="checkbox"/>	
COPD <input type="checkbox"/> <input type="checkbox"/>	History of Heartburn <input type="checkbox"/> <input type="checkbox"/>	
	Ulcers <input type="checkbox"/> <input type="checkbox"/>	

Females Males

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Breast Lumps <input type="checkbox"/> <input type="checkbox"/>	Enlarged Prostate <input type="checkbox"/> <input type="checkbox"/>
Gynecological Problems <input type="checkbox"/> <input type="checkbox"/>	Prostate Cancer <input type="checkbox"/> <input type="checkbox"/>

Joints & Muscles	Yes	No	Blood Disorders	Yes	No	Pshychological	Yes	No	Other
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Other Chronic Medical Problems: _____ _____ _____ _____ _____ _____
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Platelet Problems	<input type="checkbox"/>	<input type="checkbox"/>	Panic Attacks	<input type="checkbox"/>	<input type="checkbox"/>	
Spinal Stenosis	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Gums/Nose	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	
Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	
Hip Replacement	<input type="checkbox"/>	<input type="checkbox"/>				Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Knee Replacement	<input type="checkbox"/>	<input type="checkbox"/>				Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	

OPERATIONS (List All Surgeries Along with Year of that Surgery)

Surgery: _____ Year: _____

Alcohol	Currently Use: Yes <input type="checkbox"/> No <input type="checkbox"/>	Former Use: Yes <input type="checkbox"/> No <input type="checkbox"/>
Beer Wine Liquor	Amount (per day): _____	
Illicit Substances	Currently Use: Yes <input type="checkbox"/> No <input type="checkbox"/>	Former Use: Yes <input type="checkbox"/> No <input type="checkbox"/>
Heroin Cocaine	Amount (per day): _____	
Marijuana Other		
Caffeine	Currently Use Coffee: Yes <input type="checkbox"/> No <input type="checkbox"/>	Currently Use Soda: Yes <input type="checkbox"/> No <input type="checkbox"/>
	Amount: _____	Amount: _____
Diet - Salt Intake	Fat Intake	Sugar Intake
Low Moderate High	Low Moderate High	Low Moderate High
Exercise Yes <input type="checkbox"/> No <input type="checkbox"/>	How Long _____ Min.	How Often _____ /Week
If Yes, Type: _____		

Current Medications

Name / Dose / Times Per Day	Name / Dose / Times Per Day
_____ 1/d 2/d 3/d 4/d 5/d	_____ 1/d 2/d 3/d 4/d 5/d
_____ 1/d 2/d 3/d 4/d 5/d	_____ 1/d 2/d 3/d 4/d 5/d
_____ 1/d 2/d 3/d 4/d 5/d	_____ 1/d 2/d 3/d 4/d 5/d
_____ 1/d 2/d 3/d 4/d 5/d	_____ 1/d 2/d 3/d 4/d 5/d
_____ 1/d 2/d 3/d 4/d 5/d	_____ 1/d 2/d 3/d 4/d 5/d
_____ 1/d 2/d 3/d 4/d 5/d	_____ 1/d 2/d 3/d 4/d 5/d

Drugs or Substances (Including IV (Iodine) Dye) You Are Allergic or Intolerant Of

Drug or Substance	Reaction
_____	_____
_____	_____
_____	_____

Iodine/X-Ray Dye Allergy Yes No

Other Information

Married: _____ Single: _____ Divorced: _____ Widowed: _____

Children: _____ Males: _____ Females: _____ Ages: _____

Occupation: _____ Retired: Yes No

Guardian/Next of Kin: Name: _____ Relationship: _____

Patient Signature: _____

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Date:

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