New Patient Intake Form

Patient Name________________________ DOB____________ Age______ Date____________

Primary Care Physician____________________ Referring Physician ____________________

PLEASE ANSWER ALL QUESTIONS
What is your reason for today's visit? ____________________

1. When did the problem/discomfort start? ____________________
2. Where is the problem/discomfort located? ____________________
3. What makes it worse? ____________________
4. If there are any other symptoms associated with this problem please describe ____________________

____

GENERAL REVIEW OF SYSTEMS Are you currently having any of the following symptoms? (Please circle yes or no)

Constitutional:
Y N Recent weight change
Y N Fever
Y N Chills
Y N Fatigue

Eyes:
Y N Blurred/impaired vision

ENT:
Y N Hearing loss
Y N Ringing in ears
Y N Nose bleeds
Y N Bleeding gums
Y N Sore throat or voice change
Y N Swollen glands in neck

Cardiovascular:
Y N Chest pains/discomfort
Y N Sudden heart beat changes
Y N Palpitations/racing heart beat
Y N Swelling of feet, ankles or hands

Respiratory:
Y N Frequent coughing
Y N Sputum productive cough
Y N Spitting up blood
Y N Shortness of breath
Y N Asthma or wheezing

Gastrointestinal:
Y N Loss of appetite
Y N Change in bowel movements
Y N Nausea
Y N Vomiting
Y N Frequent diarrhea
Y N Painful bowel movements/constipation
Y N Blood in stool
Y N Stomach pain
Y N Heartburn
Y N Reflux

Genitourinary:
Y N Frequent urination
Y N Burning or painful urination
Y N Blood in urine
Y N Incontinence or dribbling
Y N Kidney stones
Y N Sexual difficulty
Y N Erection Problems

Musculoskeletal:
Y N Joint pain
Y N Joint stiffness or swelling
Y N Weakness of muscles/joints
Y N Muscle pain or cramps
Y N Back pain
Y N Cold extremities
Y N Leg pain with walking
Y N Leg swelling
Y N Limb weakness

Skin:
Y N Rash
Y N Itching skin
Y N Change in skin color
Y N Varicose veins
Y N Easily bruise
Y N Non-healing sores

Psychiatric:
Y N Memory loss or confusion
Y N Nervousness
Y N Depression
Y N Sleep problems
Y N Suicidal thoughts

Neurological:
Y N Syncope/Passing out
Y N Near Syncope
Y N Headaches
Y N Lightheaded
Y N Dizziness
Y N Convulsions or seizures
Y N Numbness or tingling
Y N Tremors
Y N Paralysis
Y N Stroke
Y N Head injury
Y N Slurred speech

Endocrine:
Y N Thyroid disease
Y N Diabetes
Y N Excessive thirst
Y N Excessive urination
Y N Heat or cold intolerance
Y N Dry skin

Hematologic/Lymphatic:
Y N Slow to heal after cuts
Y N Bleeding tendencies
Y N Anemia

Adverse Reactions to:
Y N Penicillin or antibiotics
Y N Morphine. Demerol, narcotics
Y N Novocain, other anesthetics
Y N Aspirin or other pain remedies
Y N Tetanus antitoxin, other serum
Y N Iodine, methiolate, antiseptics

List all allergies that you have: ____________________

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Please See Reverse Side

Thank you for completing all questions

Please list all PRESCRIPTION medications that you take

Name	Dose	Frequency

List all OVER THE COUNTER medications that you take

Name	Dose	Frequency

Past Medical History: (Check all that apply)

_____	Heart Disease	_____	Previous Heart Attack	_____	Asthma	_____	Cancer
_____	Heart Valve Problems	_____	High Blood Pressure	_____	COPD	_____	Bleeding Disorder
_____	Pacemaker	_____	High Cholesterol	_____	Thyroid Disease	_____	HIV Disease/exposure
_____	Heart Failure	_____	Blood Clot in Legs	_____	Liver Disease	_____	Hepatitis (A, B or C)
_____	Heart Block	_____	Blood Clot in Lungs	_____	Kidney Disease		_____________________
_____	Hereditary Heart Defect	_____	Lung Problems	_____	Stroke		_____________________
_____	Heart Murmur	_____	Emphysema	_____	Diabetes		_____________________

Please provide information about previous surgeries and hospitalizations (include date or year)

Surgeries / Procedures		Hospitalizations	
Coronary Bypass_______________________	Date___________	Admitted for__________________________	Date _________
Cardiac Cath__________________________	Date___________	______________________________________	Date_________
Angioplasty / Stent_____________________	Date___________	______________________________________	Date_________
Pacemaker____________________________	Date___________	______________________________________	Date_________
Defibrillator__________________________	Date___________	______________________________________	Date_________
Other________________________________	Date___________	______________________________________	Date_________
_____________________________________	Date_________	______________________________________	Date_________

Please provide information about previous testing (include date and location)

Stress Test	Date ___________	Location ______________	Holter Monitor	Date__________	Location_____________________
Nuclear Test	Date ___________	Location ______________	Event Monitor	Date__________	Location______________________
Echo	Date ____________	Location ______________	Heart Scan	Date__________	Location______________________
24 hr BP Monitor	Date ____________	Location ______________	PAD Net	Date__________	Location______________________

Does anyone in your family have or had Heart Disease, Heart Attack, Stroke, High Cholesterol, High Blood Pressure, Diabetes, Diabetes, Sudden Death or Cancer?

Father	Age ____	Disease(s) ________________________________	Case of death, if deceased ________________________________
Mother	Age ____	Disease(s) ________________________________	Case of death, if deceased ________________________________
Siblings	Age ____	Disease(s) ________________________________	Case of death, if deceased ________________________________
________	Age ____	Disease(s) ________________________________	Case of death, if deceased ________________________________
________	Age ____	Disease(s) ________________________________	Case of death, if deceased ________________________________

Social History:

Cigarette Smoking:	Never	Current: ____ pack(s) per day, _____ year's total		Previous: ______ year quit	
Use of Alcohol:	Never	Rare/Social	Moderate	Daily: amount per day __________	Previous: _________year quit
Use of Caffeine:	Never	Rare/Social	Moderate	Daily: amount per day __________	Previous: _________year quit
Exercise Level:	Never	Rare	Moderate	Daily ____times per week Type of exercise: _________________	
Special Diet:	Low Fat	Low Cholesterol	Vegetarian	Other: ____	
Employment:	Full Time	Part time	Retired	Unemployed	Other: __________________________

Patient Signature____ **Date**_________________