

Medical Intake Form

Date: _____

Patient Name: _____ Age : _____ Date of Birth: _____

Gender: Female Male

Marital Status: _____

#Children: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ E-mail: _____

Person to Contact in Case of Emergency: _____

Relationship to Patient: _____

Phone: _____

How Did You Hear About Us?

Yellow Pages

Other Practitioner

Who? _____

Internet

Current Patient

Who? _____

Our Website

Other _____

If patient is a Minor, Name of Parent/Guardian(s)

Medical Intake Form

HEALTH CONCERNS	HOSPITALIZATIONS, SURGERIES, AND MAJOR ILLNESSES	
Please list your current health concerns in order from most bothersome to least bothersome. Please include Mental, Emotional, and Physical concerns 1) _____ 2) _____ 3) _____ 4) _____ 5) _____	Date	Condition or Procedure 1) _____ 2) _____ 3) _____ 4) _____ 5) _____

MEDICATIONS		
Please list the medication and dosages that you are currently taking. Please include both prescription and over the counter.		
	Medication	Dosage
1)	_____	_____
2)	_____	_____
3)	_____	_____
4)	_____	_____
5)	_____	_____
6)	_____	_____

SUPPLEMENTS			
Please list all of the supplements that you are currently taking including dosages and brand names.			
	Supplement	Dosage	Brand
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____
6)	_____	_____	_____
7)	_____	_____	_____
8)	_____	_____	_____

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ALLERGIES

Please list any medication, food, environmental or other allergy.

- 1) _____
- 2) _____
- 3) _____

FAMILY HISTORY

	Children	Mother	Father	Siblings	Grandparents
Thyroid Problems					
Diabetes					
Tuberculosis					
Hypoglycemia					
Stroke					
Heart Attack					
Epilepsy/Seizures					
Cancer					
Asthma					
Allergies					
Anemia					
Migraines					
Hepatitis					
Heart Disease					
Birth Defect					
High Blood Pressure					
Gall Bladder					
Arthritis					
Alcoholism/addiction					

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NOW	PAST	GENERAL SYMPTOMS	NOW	PAST	EYES
		Tired, weak, lack of energy			Nearsightedness or farsightedness
		Depression, moodiness			Blurred or failing vision
		Worry, anxiety, nervousness			Dry, burning or itching eyes
		Sleeplessness or too much sleep			Eyes water excessively
		Frequent colds or other illnesses			Night blindness
		Headaches			Bloodshot, red or puffy eyes
		Dizziness, fainting, blacking out			Mucus or discharge in eyes
		Don't sweat enough/too much sweat nightsweats			Pain in eyes

NOW	PAST	EARS	NOW	PAST	CHEST
		Earaches			Cough frequently
		Noises or ringing in ears			Spitting up mucous or blood
		Ear discharges			Difficultly breathing
		Loss of hearing			Chest pain
		Excess earwax			Wheezing
		Difficulty hearing			Palpitations

NOW	PAST	SKIN & HAIR	NOW	PAST	NOSE & THROAT
		Acne or pimples			Allergies, sinusitis, runny nose
		Hives			Dry mouth or nose
		Stretch marks			Nosebleeds
		Skin ulcers or sores			Cracks in corners of mouth
		Dryness, roughness or scaling skin			Dry or chapped lips
		Hair loss or thinning			Sore throats or tonsillitis
		Dry, course hair			Sore, red, or cracked tongue
		Bruise easily			Cold sores or herpes
		Nails weak, ridged or split easily			Loss of smell or taste
		Brown spots or bronzing on skin			Bleeding gums
		Warts, moles or skin tags			Hoarseness
		Sunburn easily			Grinding teeth
		Cuts heal slowly or scar badly			Dental problems
		Flush easily			Difficulty swallowing
		Athletes foot.			

NOW	PAST	GASTROINTESTINAL	NOW	PAST	CARDIOVASCULAR
		Loss of appetite			Heart beats fast or irregularly
		Nausea or vomiting			Tightness in chest
		Bad breath			Discomfort in high altitude
		Metallic or bitter taste in mouth			Dizzy or weak on standing
		Heartburn			Swollen feet, ankles or legs
		Indigestion			Cold hands or feet
		Heaviness after eating			Hands or feet turn blue
		Bloating or gas			Leg pain with walking
		Belching			High blood pressure
		Constipation			Low blood pressure
		Diarrhea	NOW	PAST	URINARY
		Light colored or greasy stools			Difficulty urinating
		Undigested food in stool			Urinate frequently at night
		Blood in stool or on paper			Bed Wetting
		Hemorrhoids			Incomplete urination or dribbling
		Foul odor of stool or gas			Pain when urinating
		Rectal pain/itching			Bladder or kidney infection

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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urine leakage
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine

NOW	PAST	FEMALE	NOW	PAST	MALE
<input type="checkbox"/>	<input type="checkbox"/>	Irregular periods	<input type="checkbox"/>	<input type="checkbox"/>	Prostate problems
<input type="checkbox"/>	<input type="checkbox"/>	Pain prior to or with periods	<input type="checkbox"/>	<input type="checkbox"/>	Sexual difficulty
<input type="checkbox"/>	<input type="checkbox"/>	Depressed irritable around periods	<input type="checkbox"/>	<input type="checkbox"/>	Genital discharge
<input type="checkbox"/>	<input type="checkbox"/>	Painful or swollen breasts	<input type="checkbox"/>	<input type="checkbox"/>	Rashes or sores
<input type="checkbox"/>	<input type="checkbox"/>	Lumps in breast	<input type="checkbox"/>	<input type="checkbox"/>	Pain in genitals
<input type="checkbox"/>	<input type="checkbox"/>	Nipple discharge	<input type="checkbox"/>	<input type="checkbox"/>	Painful testicles
<input type="checkbox"/>	<input type="checkbox"/>	Vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>	Prostate problems
<input type="checkbox"/>	<input type="checkbox"/>	Vaginal pain or itching	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Diminished or excessive sex drive	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty reaching orgasm	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Inability to conceive	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Miscarriages or abortions	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Pelvic pain	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Pain with intercourse	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Heavy periods	<input type="checkbox"/>	<input type="checkbox"/>	

CONDITIONS

Please check any conditions you have had.

<input type="checkbox"/>	AIDS	<input type="checkbox"/>	Chemical Dependency	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Prostate Problems
<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	Psoriasis/Eczema
<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Psychiatric Care
<input type="checkbox"/>	Anorexia	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Leg Cramps	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	Scarlet Fever
<input type="checkbox"/>	Appendicitis	<input type="checkbox"/>	Gall Bladder Disease	<input type="checkbox"/>	Measles	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	Suicide Attempt
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Goiter	<input type="checkbox"/>	Miscarriage	<input type="checkbox"/>	Thyroid
<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	Gonorrhea	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	Tonsillitis
<input type="checkbox"/>	Breast Lump	<input type="checkbox"/>	Gout	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	Typhoid Fever
<input type="checkbox"/>	Bulimia	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Vaginal Infections
<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	Polio	<input type="checkbox"/>	Venereal Disease

I certify that the above information is correct to the best of my knowledge.

Signature: _____ Date: _____

Print Name: _____