MEDICAL INTAKE FORM

Patient Name: _____

Date of Birth: _____ Telephone Number _____

Past Medical History: Circle any of the following that you have had.

Allergies or Asthma	Congestive Heart Failure		Migraines
	Depression	Hepatitis (Jaundice)	Phlebitis
Anemia	Diabetes	High Blood Pressure	Psoriasis
Arthritis		Heart Blockage	
Breast lumps/cysts	Eczema-Hives	Kidney Stones	Stroke
Cancer (Tumors)	Epilepsy or Seizures	Liver Disease	
Cataracts	Heart Attack	Lung Disease	Thyroid Disease

Other: _____

Medications: [List all you are taking, the dosage (strength), and how often you take it.]

1. _____ 4 _____
2. _____ 5 _____
3. _____ 6 _____

Drug Allergies: _____

Review of Systems:

Within the last 6 months have you had problems with	Yes	No	Describe
General fatigue, weight loss, etc.)			
Eyes (blurriness, burning, vision, etc.)			
Ears, Nose, Throat (Drainage, bleeding, hard to swallow, etc.)			
Lungs or Breathing (Shortness of breath, cough, wheeze, etc.)			
Heart (chest pains, murmur, skipping, etc.)			
Bones/Joints (swelling, stiffness, pain, etc.)			
Skin (rashes, ulcers, etc.)			
Depression, feeling uptight, sleep problems			
Glands (problems with heat/cold, urine, eating, dry skin, hair change)			

In the past 24 hours,

	YES	NO
1. Have you had any problems with your heart? (Palpitations, murmur, chest pain, heart attack, etc.)	_____	_____
2. Have you had any problems with blood pressure?	_____	_____
3. Have you had any problems with your lungs? (Breathing problems, cough, asthma, emphysema, bronchitis)	_____	_____
4. Do you have a severe cold, cough, nasal congestion or fever now?	_____	_____
5. Do you have diabetes? If yes, how many years? _____	_____	_____
6. Do you take insulin injections?	_____	_____
7. Have you had hepatitis, jaundice?	_____	_____
8. Have you had any kidney or bladder problems?	_____	_____
9. Have you received blood transfusions? If so, when? _____	_____	_____
10. Have you had convulsions or seizures?	_____	_____
11. Have you had psychiatric problems?	_____	_____
12. Any back problems?	_____	_____
13. Have you had any problems with anemia?	_____	_____
14. Have you had any problems with excessive bleeding?	_____	_____
15. Have you had a history of stomach ulcers/hiatal hernia/indigestion?	_____	_____
16. Do you have loose teeth, dentures, caps, or crowns? (If yes, please circle)	_____	_____
17. Do you smoke? If so, how many packs a day? ____ How many years? ___	_____	_____
18. Do you drink alcohol? If so, how much? _____	_____	_____
19. Any muscle disease in your family? (Muscular Dystrophy, Multiple Sclerosis, etc.)	_____	_____