

INTAKE FORM

Please use black or blue ink & do NOT print double-sided

NAME _____ DOB _____ AGE _____ DATE ____ / ____ / ____
First MI Last

How would you like to be addressed? _____ Gender: Female Male

Primary Care

Name _____ Address _____ Telephone number _____

Pharmacy

Name _____ Address _____ Telephone number _____

Reason for visit: _____

If the reason for your visit is a STUDY, please initial the following statement:

____ I am currently not participating in any other clinical trials at other locations

MEDICAL HISTORY AND REVIEW OF SYMPTOMS

Condition	When?	Date First Diagnosed	Date Resolved	Taking Medication?	Office Use Only
Dermatological (Skin)	None <input type="checkbox"/>				
Precancer/Cancer	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Rash	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Abnormal mole	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Other skin conditions: _____	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Neurological (Nervous system)	None <input type="checkbox"/>				
Migraines / Headaches	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Depression	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Anxiety	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Psychiatric Care/ Hospitalization	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Epilepsy/Seizures	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Other: _____	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Cardiovascular (Heart & blood)	None <input type="checkbox"/>				
Heart Murmur	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Irregular Heart Rate/Palpitations	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Chest Pain	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Heart Attack	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
High Blood Pressure	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Elevated Cholesterol	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Other: _____	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Pulmonary (Lungs)	None <input type="checkbox"/>				
Asthma	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
COPD	Now <input type="checkbox"/> In the past <input type="checkbox"/>				

Persistent Cough	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Other: _____	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Gastrointestinal (Digestion)	None <input type="checkbox"/>				
Ulcers	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Hepatitis / Liver Problems	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Gall Bladder Disease	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Heartburn/GERD	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Chronic Constipation	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Diarrhea	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Persistent Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/>	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Blood in Stool	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Other: _____	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Urologic (Kidneys & Bladder)	None <input type="checkbox"/>				
Frequent Urinary Tract Infection	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Kidney Infection	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Kidney Disease	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Bladder Problems Incontinence (leaking) Urinary Frequency Urinary Urgency	Now <input type="checkbox"/> In the past <input type="checkbox"/> Now <input type="checkbox"/> In the past <input type="checkbox"/> Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Blood in Urine	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Other: _____	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Musculoskeletal(Muscles& Bones)	None <input type="checkbox"/>				
Osteoporosis <input type="checkbox"/> Osteopenia <input type="checkbox"/>	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Arthritis: Type _____	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Fibromyalgia	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Fractures	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Other: _____	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Eyes, Ear, Nose, Throat	None <input type="checkbox"/>				
Glaucoma -Type _____	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Hearing Problems	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Seasonal Allergies/Hay Fever	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Cataracts	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Other eye problems: _____	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Current dental issues?	Yes <input type="checkbox"/> No <input type="checkbox"/>				
Other: _____	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Endocrine (Glands)	None <input type="checkbox"/>				
Diabetes Mellitus: Type I or II	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Thyroid Disease	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Other: _____	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Hematology (Blood Disorders)	None <input type="checkbox"/>				
Anemia	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Blood Clots / Pulmonary Embolism	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Other: _____	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Lupus/ SLE	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Cancer	None <input type="checkbox"/>				
Cancer Type: _____	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Cancer Type: _____	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Cancer Type: _____	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Cancer Type: _____	Now <input type="checkbox"/> In the past <input type="checkbox"/>				

SURGICAL HISTORY (Including Cosmetic Surgery)

Surgery type	Date(s)	Reason	Where was it done (Hospital/City)?

FAMILY MEDICAL HISTORY

Relative	Living ?	Major Medical Problems (i.e. stroke, heart attack)
Mother		
Father		
Siblings		
Siblings		
Siblings		
Other		

CURRENT MEDICATIONS

Medications you are taking currently (include those you buy at the drug store, health food store)					
Medications, Vitamins, and/or Health supplements	Dose (e.g. 10mg)	How often? (e.g. twice a day)	Start Date	Stop Date (If applicable)	Reason taken (e.g. cholesterol)
Other Medications you have taken in the past 3 months					

MEDICATION(DRUG) / FOOD ALLERGIES

Medication or Food	Reaction	Date you first had this reaction

PERSONAL HEALTH HABITS

Occupation: _____			Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/>		
Tobacco use? How much per day? _____			Year started _____ Year quit _____		
Alcohol use? YES <input type="checkbox"/> NO <input type="checkbox"/>		Average number of drinks per week _____			
Current or past history of substance abuse? YES <input type="checkbox"/> NO <input type="checkbox"/> Dates: _____					
Do you exercise? _____		How often? _____		Any dietary restrictions? _____	

IMMUNIZATIONS

Yearly flu shot? YES <input type="checkbox"/> NO <input type="checkbox"/>		Date of last tetanus shot _____ (recommended every 10 years)			
Have you had a Measles/Mumps/Rubella vaccine? YES <input type="checkbox"/> NO <input type="checkbox"/>					
Have you had a varicella vaccine (or had chicken pox)? YES <input type="checkbox"/> NO <input type="checkbox"/>					
If age 65 or over, have you had a pneumococcal vaccine? YES <input type="checkbox"/> NO <input type="checkbox"/>					
Ever been tested for Tb? YES <input type="checkbox"/> NO <input type="checkbox"/>		Was it positive? YES <input type="checkbox"/> NO <input type="checkbox"/>		BCG Vaccine YES <input type="checkbox"/> NO <input type="checkbox"/>	
Have you had the series of vaccines for HPV (Human Papilloma Virus)? YES <input type="checkbox"/> NO <input type="checkbox"/>					
I've had: All three vaccines <input type="checkbox"/> The first one only <input type="checkbox"/> Two vaccines <input type="checkbox"/>					

FEMALES:

OBSTETRIC HISTORY (PREGNANCY)

Date	Type of Delivery	Complications of pregnancy

OTHER PREGNANCIES- MISCARRAGES/ ABORTIONS/ ECTOPICS

Date	Outcome

GYNECOLOGICAL HISTORY

Last Menstrual Period:		Method of Birth Control:			
Age of 1 st menstrual period:					
Menses last ____ days and come every ____ days : ____ heavy ____ medium ____ light					
Last Pap:		If any abnormal paps, when and how was it treated:			
Last mammogram:		Where:			
Any abnormal mammograms and when:					
Breast procedures/ Ultrasound/ MRI?					
Breast Implants? Type:					
Lifetime sexual partners ____ 1-5 ____ 6-20 ____ > 20					
Condition	When?	Date First Diagnosed	Date Resolved	Taking Medication?	Office Use Only
Genital Infections: <input type="checkbox"/> Bacterial Vaginosis <input type="checkbox"/> Gonorrhea <input type="checkbox"/> HPV <input type="checkbox"/> Chlamydia <input type="checkbox"/> Herpes <input type="checkbox"/> Other: _____					
Uterine fibroids	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Ovarian Cyst	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Vaginal Dryness	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Decreased Sex Drive	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Painful intercourse	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Irregular Bleeding	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Painful Periods	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Other: _____	Now <input type="checkbox"/> In the past <input type="checkbox"/>				

MALES:

Condition	When?	Date First Diagnosed	Date Resolved	Taking Medication?	Office Use Only
Reproductive	None <input type="checkbox"/>				
Genital Infections: <input type="checkbox"/> Bacterial Vaginosis <input type="checkbox"/> Gonorrhea <input type="checkbox"/> HPV <input type="checkbox"/> Chlamydia <input type="checkbox"/> Herpes <input type="checkbox"/> Other: _____					
Prostate Problems	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Decreased Sex Drive	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Erectile Dysfunction	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Other: _____	Now <input type="checkbox"/> In the past <input type="checkbox"/>				

Patient Signature _____ **Date** _____

Reviewed by **Provider:** _____ **Date** _____

Reviewed by **CRC** (if applicable) _____ **Date** _____