NEW PATIENT INTAKE FORM - ACUTE

Patient's Name:				☐M ☐F	Date of Birth:	
Marital Status:	☐ Married	☐Single	☐Divorced	☐Separated	☐Widowed	☐Partnered
Highest Education Level:						
Current Weight:		Maximum Weight:		Ideal Weight:		Height:

Please list your current health concerns in order of importance:
1
2
3
4
5

Please list any medical problems diagnosed by other doctors:

Please list all surgeries and hospitalization:		
Date	Reasons:	Hospital:

Please list when and why you had the following:	
X-Ray:	
MRI/Cat Scans:	
Ultrasounds:	
Accidents:	
TB Tests:	
HIV:	

HCV:	
Last Eye Exam:	
Last Dental Visit:	

Please list the prescribed medication you are currently taken?		
Name:	Strength:	Frequency taken:

Please list the over the counter medications and supplements you are currently taken?		
Name:	Strength:	Frequency taken:

Please list any allergies to medication or foods:	
Name:	Reaction you had:

Please list Yes (Y), No (N), or Past (P) regarding the use of the following:	
Smoking: ☐Y ☐N ☐P If yes, how many a day?	
Coffee: ☐Y ☐N ☐P	
Soda pop: ☐Y ☐N ☐P If yes, how many a day?	
Alcohol: ☐Y ☐N ☐P If yes, how much a day?	
Laxatives: ☐Y ☐N ☐P	
Antacids: ☐Y ☐N ☐P	
Any alcohol addiction: ☐Y ☐N ☐P Recreational drugs: ☐Y ☐N ☐P	Any alcohol treatment: ☐Y ☐N ☐P Any drug addiction: ☐Y ☐N ☐P

WOMAN ONLY		
Age of menstruation:	Date of last menstruation:	
Length of period:	Quality of period: ☐Heavy ☐Irregular ☐Spotting ☐Pain	
Do you have any ☐tension, ☐pain, ☐bloating, ☐irritability or ☐ other symptoms around or during your period?		
Number of pregnancies:	Number of live births:	Are you breastfeeding? ☐Yes ☐ No
Have you had ☐D&C, ☐Hysterectomy, or ☐Cesarean?		
Have you had any ☐urinary tract, ☐bladder, or ☐kidney infections within the last year?		
Do you have any hot flashes or sweating at night? ☐Yes ☐No		
Do you have vaginal dryness? ☐Yes ☐No		
Do you have pain with intercourse? ☐Yes ☐No		
When did you start menopause?		
Have you experienced any recent ☐breast tenderness, ☐lumps or ☐nipple discharge?		
What is your sexual orientation? ☐Hetero ☐Homo ☐Bi		
Have you had any STD? ☐Yes ☐No		
Date of last pap smear:	Result:	
Date of last mammogram:	Result:	
Date of last Dexa Scan:	Result:	

MAN ONLY
What is your sexual orientation? ☐Hetero ☐Homo ☐Bi
Do you usually get up to urinate during the night? ☐Yes ☐No
Do you feel pain or burning during urination? ☐Yes ☐No
Do you have any blood in your urine? ☐Yes ☐No
Do you feel burning discharge from penis? ☐Yes ☐No
Has the force of your urination decreased? ☐Yes ☐No
Have you had any ☐urinary tract, ☐bladder, or ☐kidney infections within the last year?
Do you have nay problem emptying your bladder completely? ☐Yes ☐No
Do you have any difficulty with erection or ejaculation? ☐Yes ☐No
Do you have any testicle pain or swelling? ☐Yes ☐No
Do you have any hernia? ☐Yes ☐No
Have you had any STD? ☐Yes ☐No
Date of last prostate and rectal exam: