History Intake Form

Age:________________________

Patient name____ **Birth Date:**__________________

Please list the reason you are here to see doctor

____

If accident or injury, date of:____

How did accident happen?____

____

Please answer all of the questions as accurately as possible. If you do not understand the question please ask for assistance.

Primary Care Doctor:____________________ **Referring Physician:**__________________________

List any medications you are taking, including non-prescription drugs, vitamins, and herbals:

____

____

Drug allergies:____

____

List Previous surgeries and dates:____

____

List previous major illnesses and dates:____

____

Patient's Past Medical History:

Have you ever had the following

Heart disease……………	no	yes	Kidney Disease……...	no	yes	AIDS or HIV+………….	no	yes
High Blood Pressure……	no	yes	Stroke………………..	no	yes	Glaucoma……………….	no	yes
Rheumatic fever………..	no	yes	Diabetes……………..	no	yes	Cancer………….……...	no	yes
Mitral valve Prolapse…..	no	yes	Thyroid Disease……..	no	yes	Stomach Ulcer…………...	no	yes
Heart Failure……………	no	yes	Arthritis………………	no	yes	Bleeding Tendency………	no	yes
Asthma………………….	no	yes	Anemia……………….	no	yes	Reaction to Anestetic.……	no	yes
Hepatitis…………………	no	yes	Tuberculosis…………	no	yes			

Social History

Type of Work______________________________

Do you smoke? Yes No (type & amt. per day)______________ Alcohol (type and amt. per week)___________________

If former smoker, length of time smoked:_________date quit:_______ Weight:______________Height:_________________

Family History:

Has any blood relative ever had the following:

Breast Cancer…………..	no	yes	High Blood Pressure…	no	yes	Kidney Disease………….	no	yes
Melanoma……………...	no	yes	Heart Disease…………	no	yes	Depression………………	no	yes
Stroke…………………..	no	yes	Diabetes………………	no	yes	Reaction to anesthetics….	no	yes
						Bleeding Tendency………	no	yes

Review the Systems:

Do you have or have you had within the past year:

Weight change………..	no	yes	Swollen feet/ankles….	no	yes	Seizures…………………..	no	yes
Dry eyes………………	no	yes	Skin Rash……………	no	yes	Joint or muscle pain……...	no	yes
Chronic cough………..	no	yes	Chronic diarrhea…….	no	yes	Swollen lymph nodes…….	no	yes
Chest pain…………….	no	yes	Jaundice……………..	no	yes	Easy bleeding…………….	no	yes
Rapid heart beat………	no	yes	Depression…………..	no	yes	Easy bruising……………..	no	yes

Women only:

Age Period began______________________ Number of Pregnancies______________________

Date of last mammogram________________ Did you breast feed? No Yes

Do you do regular breast self examinations?_________ Breast lump discharge? No Yes

I VERIFY THAT EH ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE

X____ ______________________________

Signature of patient or Parent if minor Date

PHYSICIAN: MARK OWSLEY M. D.