

History Intake Form

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MR# _____

DATE _____

Please complete all questions. Be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. An initial evaluation is required to determine whether you are a suitable candidate and whether the practice will accept you as a patient.

Patient Name _____ Birth Date _____

*Height _____ *Weight _____ *BP (Staff will assist) _____ Race _____ Preferred Language (English, Spanish, etc.) _____

Preferred Contact Method (check one): Phone _____ Cell _____ Email _____

Pharmacy Name and Location _____

Primary Care Doctor _____ City _____ State _____

Did a doctor refer you to our office? Yes/No If yes, whom? _____ City _____ State _____

SKIN CANCER HISTORY: Please list any prior skin cancers. Your nurse or medical assistant will assist if needed.

Diagnosis	Location	Treatment Date	Treatment Method

PAST MEDICAL HISTORY: Have you ever had or currently have the following? Circle Yes or No

No known past medical history.

CONDITION	PATIENT
Anxiety	Yes No
Arthritis	Yes No
Asthma	Yes No
A Fib (irregular heartbeat)	Yes No
BPH (enlarged prostate)	Yes No
Bone Marrow Transplant	Yes No
Breast Cancer	Yes No
Colon Cancer	Yes No
COPD	Yes No
Coronary Artery Disease	Yes No

CONDITION	PATIENT
Depression	Yes No
Diabetes	Yes No
Kidney Disease	Yes No
Gastric Reflux	Yes No
Hearing Loss	Yes No
Hepatitis	Yes No
*High Blood Pressure	Yes No
Controlled w/Medication	Yes No
HIV/AIDS	Yes No
High Cholesterol	Yes No

CONDITION	PATIENT
Hyperthyroidism	Yes No
Hypothyroidism	Yes No
Leukemia	Yes No
Lung Cancer	Yes No
Lymphoma	Yes No
Prostate Cancer	Yes No
Radiation Treatment	Yes No
Seizures	Yes No
Stroke	Yes No
Other:	

PAST SURGICAL HISTORY: Have you ever had the following? No surgeries

Functional Status Test: Please provide the date you followed up with your provider/surgeon after your joint replacement.

<input type="checkbox"/> Appendix Removal (Appendectomy)	<input type="checkbox"/> Colon: Diverticulitis	<input type="checkbox"/> Ovaries: Oophorectomy
<input type="checkbox"/> Bladder Removal (Cystectomy)	<input type="checkbox"/> Colon: IBD	<input type="checkbox"/> Ovaries: Endometriosis <input type="checkbox"/> Ovaries: Ovarian Cyst
<input type="checkbox"/> Breast: Mastectomy (Right Breast)	<input type="checkbox"/> Gallbladder (Cholecystectomy)	<input type="checkbox"/> Ovaries: Ovarian Cancer
<input type="checkbox"/> Breast: Mastectomy (Left Breast)	<input type="checkbox"/> Heart: Bypass Surgery	<input type="checkbox"/> Prostate: Prostate Cancer
<input type="checkbox"/> Breast: Mastectomy (Both Breasts)	<input type="checkbox"/> Heart: PTCA	<input type="checkbox"/> Prostate: Prostate Biopsy
<input type="checkbox"/> Breast: Lumpectomy (Right Breast)	<input type="checkbox"/> Heart: Mechanical Valve Replacement	<input type="checkbox"/> Prostate: TURP (Prostatectomy)
<input type="checkbox"/> Breast: Lumpectomy (Left Breast)	<input type="checkbox"/> Heart: Biological Valve Replacement	<input type="checkbox"/> Skin Biopsy
<input type="checkbox"/> Breast: Lumpectomy (Both Breasts)	<input type="checkbox"/> Heart: Heart Transplant	<input type="checkbox"/> Spleen Removal (Splenectomy)
<input type="checkbox"/> Breast: Breast Biopsy	<input type="checkbox"/> Kidney: Kidney Biopsy	<input type="checkbox"/> Testicles Removal (Orchiectomy)
<input type="checkbox"/> Breast: Breast Reduction	<input type="checkbox"/> Kidney: Removal/Nephrectomy	<input type="checkbox"/> Uterus: Hysterectomy
<input type="checkbox"/> Breast: Breast Implants	<input type="checkbox"/> Kidney: Kidney Stone Removal	<input type="checkbox"/> Uterus: Uterine Cancer <input type="checkbox"/> Uterus: Fibroids
<input type="checkbox"/> Colon: Colectomy <input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Kidney: Kidney Transplant	<input type="checkbox"/> Other Surgeries:
<input type="checkbox"/> *Joint Replacement: Hip (Left) Functional Status Test ___ \ ___ \ ___		<input type="checkbox"/> *Joint Replacement: Knee (Left) Functional Status Test ___ \ ___ \ ___
<input type="checkbox"/> *Joint Replacement: Hip (Right) Functional Status Test ___ \ ___ \ ___		<input type="checkbox"/> *Joint Replacement: Knee (Right) Functional Status Test ___ \ ___ \ ___
<input type="checkbox"/> *Joint Replacement: Hip (Both) Functional Status Test ___ \ ___ \ ___		<input type="checkbox"/> *Joint Replacement: Knee (Both) Functional Status Test ___ \ ___ \ ___

SKIN HISTORY: Have you ever had or currently have the following? No skin condition history.

<input type="checkbox"/> Acne	<input type="checkbox"/> Dry Skin	<input type="checkbox"/> Poison Ivy
<input type="checkbox"/> Actinic Keratoses (Pre-cancers)	<input type="checkbox"/> Eczema	<input type="checkbox"/> Precancerous Moles
<input type="checkbox"/> Asthma	<input type="checkbox"/> Flaking or Itchy Scalp	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Basal Cell Carcinoma	<input type="checkbox"/> Hay Fever/Allergies	<input type="checkbox"/> Squamous Cell Carcinoma
<input type="checkbox"/> Blistering Sunburns	<input type="checkbox"/> Melanoma	
<input type="checkbox"/> Other Skin Conditions:		

Do you wear sunscreen? Yes No If yes, what SPF? _____ Do you go to tanning salons? Yes No

Do you have a family history of melanoma? Yes No If yes, which relative(s)? _____

***MEDICATIONS: List your medications. Please include all Rx, OTC, herbal, and vitamin supplements.**

Medication Name	Dose (example: 100 mg)	Route	Frequency (example: once a day)	Start Date/End Date

ALLERGIES: List your allergies and reaction.

Medication or Allergen	Reaction (example: rash, GI upset, etc.)

SOCIAL HISTORY: Check best response.

*Smoking Status? Every day smoker Some day smoker Former Smoker Never Smoker

Weekly alcohol consumption? None Less than 1 drink/day 1-2 drinks/day 3 or more drinks/day

REVIEW OF SYSTEMS: Have you had any of the following in the past year? No Symptoms

Abdominal Pain	Yes	No	Easy Bleeding or Bruising	Yes	No	Night Sweats	Yes	No
Anxiety	Yes	No	Fevers or Chills	Yes	No	Problems with Scarring (keloids)	Yes	No
Blood in Stool	Yes	No	Hair Loss	Yes	No	Rash	Yes	No
Blood in Urine	Yes	No	Hay Fever	Yes	No	Seizures	Yes	No
Chest Pain	Yes	No	Headaches	Yes	No	Sensitivity to Light or Sunburn Easily	Yes	No
Cough	Yes	No	Immunosuppression	Yes	No	Shortness of Breath	Yes	No
Depression or Sad Mood	Yes	No	Joint Aches	Yes	No	Sore Throat	Yes	No
Diarrhea	Yes	No	Mouth Ulcers	Yes	No	Thyroid Problems	Yes	No
Difficulty Healing Wounds	Yes	No	Muscle Weakness	Yes	No	Unintentional Weight Loss	Yes	No
Dry Eyes	Yes	No	Neck Stiffness	Yes	No	Vision Changes or Blurred Vision	Yes	No
Other Symptoms: _____								

ALERTS: Please answer the following important questions.

Are you allergic to adhesives or tape?	Yes	No
Are you allergic to numbing medicines?	Yes	No
Are you allergic to antibiotic creams?	Yes	No
Do you have an artificial heart valve?	Yes	No
Have you had a joint replaced in last 2 years?	Yes	No
Are you on any blood thinners?	Yes	No

Do you have a defibrillator?	Yes	No
Do you have a history of MRSA infections?	Yes	No
Do you have a pacemaker?	Yes	No
Do you require antibiotic prior to procedures?	Yes	No
Do you get a rapid heartbeat with numbing medicine?	Yes	No
Are you pregnant or planning to become pregnant?	Yes	No

FAMILY MEDICAL HISTORY: Please list major medical conditions of first-degree relatives.

Father _____
 Mother _____
 Brother _____ Sister _____

PREVENTATIVE CARE HISTORY:

Age period began _____ Number of pregnancies _____ Date of last pregnancy _____
 Did you breastfeed? Yes No Date of last mammogram _____ Breast lump or discharge? Yes No