

NURSING INTAKE FORM

Patient Name _____ Date of Birth _____ Date _____

Reason for your visit _____

Referring M.D. _____ Primary Care M.D. _____

Height _____ Weight _____ Right handed or Left handed

(For office use only)

BP _____ BMI _____ Growth chart (if applicable) _____

Date of last flu vaccination _____ Date of last pneumonia vaccination _____

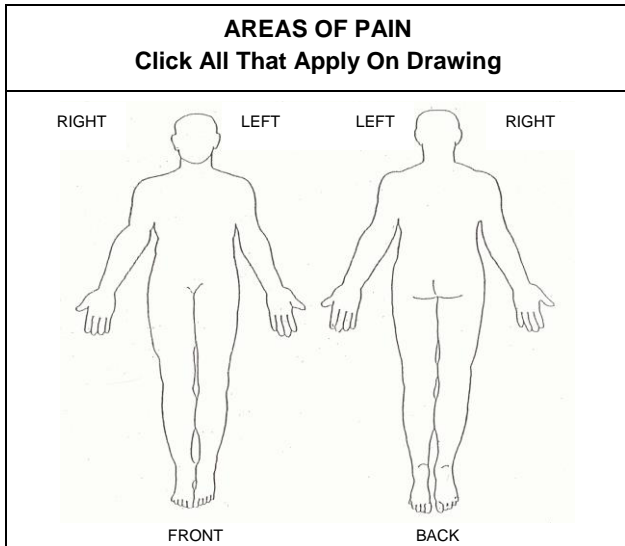
Do you smoke? No Yes (amount per day) _____

Do you use tobacco in any other form? No Yes *If yes, cigars smokeless

How many years have you used tobacco? _____

Do you drink caffeine? No Yes (amount) _____

Do you drink alcohol? No Yes (amount per day) _____



Please select your current level of pain:
(0= No pain and 10= Unbearable pain)

Family Medical History: (Please include for your mother, father, and siblings.)

Social History:

Marital status: _____ Children: _____

Occupation: _____

Level of education: _____

Past Medical History: (Please check all that apply.)

- | | | |
|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Peptic ulcer disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Sleep disorder |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Heart valve | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> TIA |
| <input type="checkbox"/> Type: _____ | <input type="checkbox"/> High cholesterol | |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hypothyroidism | |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Kidney failure | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraines | |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Parkinson's | |

Other _____

Past Surgical History: (Please check all that apply.)

- | | | |
|--|---|---|
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Cholecystectomy
(gallbladder) | <input type="checkbox"/> Neck surgery |
| <input type="checkbox"/> Back surgery | <input type="checkbox"/> Gastric bypass | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Breast surgery | <input type="checkbox"/> Hip Replacement | <input type="checkbox"/> Shoulder |
| <input type="checkbox"/> CABG (bypass) | <input type="checkbox"/> Knee (scope) | <input type="checkbox"/> Sinus |
| <input type="checkbox"/> Carotid surgery | <input type="checkbox"/> Knee replacement | <input type="checkbox"/> TAH (hysterectomy) |
| <input type="checkbox"/> Carpal tunnel | <input type="checkbox"/> Lumpectomy | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> C-Section | <input type="checkbox"/> Mitral valve | <input type="checkbox"/> Tubal ligation |

Other _____

Current Medications: (Please include dosage and how often you take the medication.)

Pharmacy Name/Address: _____

Pharmacy Phone Number: _____

Allergies/Reactions: (Please include medication, food and environmental allergies.)

Seafood allergy? No Yes

Latex allergy? No Yes

Review of Systems: (Please check symptoms that you are currently experiencing.)

<p>General</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Chills</p> <p><input type="checkbox"/> Sweats</p> <p><input type="checkbox"/> Anorexia</p> <p><input type="checkbox"/> Fatigue/weakness</p> <p><input type="checkbox"/> Malaise</p> <p><input type="checkbox"/> Weight loss</p> <p><input type="checkbox"/> Sleep Disorder</p> <p>Eyes</p> <p><input type="checkbox"/> Blurred vision</p> <p><input type="checkbox"/> Double vision</p> <p><input type="checkbox"/> Eye irritation</p> <p><input type="checkbox"/> Drainage from your eyes</p> <p><input type="checkbox"/> Vision loss</p> <p><input type="checkbox"/> Eye pain</p> <p><input type="checkbox"/> Sensitivity to light</p> <p>ENT</p> <p><input type="checkbox"/> Earache</p> <p><input type="checkbox"/> Ear drainage</p> <p><input type="checkbox"/> Ringing in your ears</p> <p><input type="checkbox"/> Decreased hearing</p> <p><input type="checkbox"/> Nasal congestion</p> <p><input type="checkbox"/> Nose bleeds</p> <p><input type="checkbox"/> Sore throat</p> <p><input type="checkbox"/> Hoarseness</p> <p>CV</p> <p><input type="checkbox"/> Chest pains/palpitations</p> <p><input type="checkbox"/> Passing out</p> <p><input type="checkbox"/> Trouble breathing w/ activity</p> <p><input type="checkbox"/> Trouble breathing unless standing</p> <p><input type="checkbox"/> Waking up at night unable to breathe</p> <p><input type="checkbox"/> Swelling in your feet</p>	<p>Resp</p> <p><input type="checkbox"/> Cough</p> <p><input type="checkbox"/> Trouble breathing at rest</p> <p><input type="checkbox"/> Excessive sputum/phlegm</p> <p><input type="checkbox"/> Coughing up blood</p> <p><input type="checkbox"/> Wheezing</p> <p><input type="checkbox"/> Pleurisy</p> <p>GI</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Change in bowel habits</p> <p><input type="checkbox"/> Abdominal pain</p> <p><input type="checkbox"/> Blood in your stool</p> <p><input type="checkbox"/> Jaundice/yellowing of your skin</p> <p><input type="checkbox"/> Gas/Bloating</p> <p><input type="checkbox"/> Indigestion/heartburn</p> <p><input type="checkbox"/> Trouble swallowing</p> <p>GU</p> <p><input type="checkbox"/> Loss of control of bladder</p> <p><input type="checkbox"/> Trouble urinating</p> <p><input type="checkbox"/> Urinary frequency</p> <p><input type="checkbox"/> Pelvic pain</p> <p>MS</p> <p><input type="checkbox"/> Back pain</p> <p><input type="checkbox"/> Joint pain</p> <p><input type="checkbox"/> Joint swelling</p> <p><input type="checkbox"/> Muscle cramps</p> <p><input type="checkbox"/> Muscle weakness</p> <p><input type="checkbox"/> Muscle stiffness</p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Sciatica</p> <p><input type="checkbox"/> Restless legs</p> <p><input type="checkbox"/> Leg pain at night/with activity</p>	<p>Derm</p> <p><input type="checkbox"/> Rash/itching/dryness to skin</p> <p><input type="checkbox"/> Suspicious lesions on skin</p> <p>Neuro</p> <p><input type="checkbox"/> Paralysis</p> <p><input type="checkbox"/> Tingling</p> <p><input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Tremors</p> <p><input type="checkbox"/> Vertigo</p> <p><input type="checkbox"/> Episodes of blindness</p> <p><input type="checkbox"/> Frequent falls</p> <p><input type="checkbox"/> Frequent headaches</p> <p><input type="checkbox"/> Difficulty walking</p> <p>Psych</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Memory loss</p> <p><input type="checkbox"/> Suicidal thoughts</p> <p><input type="checkbox"/> Hallucinations</p> <p><input type="checkbox"/> Paranoia/phobia</p> <p><input type="checkbox"/> Confusion</p> <p>Endo</p> <p><input type="checkbox"/> Cold/heat intolerance</p> <p><input type="checkbox"/> Excessive thirst/hunger</p> <p><input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> Unusual weight change</p> <p>Heme</p> <p><input type="checkbox"/> Abnormal bruising/bleeding</p> <p><input type="checkbox"/> Enlarged lymph nodes</p> <p>Allergy</p> <p><input type="checkbox"/> Itching or rash to skin</p> <p><input type="checkbox"/> Hay fever</p> <p><input type="checkbox"/> Recurrent infections</p>
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-or- You are currently not experiencing any symptoms.