MEDICAL INTAKE

Name: _____ **DOB**: ____/____/_____ **Age**: ____ **Sex**: _____

Height: _____**Weight**: _____

1. Describe your present illness or your chief complaint: _____

_____

_____

_____

2. Past medical history: Please circle yes or no

- Fainting and dizziness YES NO
- TIA or stroke YES NO
- Eyes, ears, nose, throat YES NO
- Lung condition YES NO
- Breast YES NO
- Heart condition:
    - Chest pain YES NO
    - Heart attack YES NO
    - Pacemaker YES NO
    - Defibrillator YES NO
    - Other heart conditions YES NO
- Hypertension YES NO
- Blood clots YES NO
- Phlebitis YES NO
- Varicosed veins YES NO
- Circulation problems [PVD] YES NO
- Gastrointestinal:
    - Stomach, intestines YES NO
    - Gallbladder YES NO
- Kidney and prostate conditions YES NO
- Uterus and ovaries YES NO
- Diabetes YES NO
    - Insulin dependent YES NO
- Thyroid condition YES NO
- Muscles/bones conditions, arthritis YES NO

PLEASE CONTINUE ON BACK

- Neuro/Psych, depression YES NO
- Dementia YES NO
- Hematology, cancer, bleeding disorder YES NO
- Skin condition YES NO

3. Past surgical history:_____

_____

_____

4. List all current medications, including over-the -counter:_____

_____

_____

_____

_____

5. List all allergies to medications:_____

_____

6. Family medical history: Father, mother, and siblings:_____

_____

_____

7. Smoking and drug history:

Smoking YES NO [If yes, how long and how many packs a day] _____

Alcohol intake YES NO [If yes, how often]_____

Recreational drugs YES NO [If yes, what drugs] _____

8. Please write down any questions you would like to ask the doctor today:_____

_____

_____

Today's date: _____