1960 Physician Associates

PCP & INTERNAL MEDICINE

ESTABLISHED PATIENT INTAKE FORM

PATIENT INFORMATION

Patient's Name: (Last)_____(First)_____Date: _____

Address: _____

City, State, Zip: _____

Home:_____Cell:_____Work: _____

E-Mail Address:_____DOB: _____

Primary Insurance: _____ Member ID: _____ Group Number: _____

Reason for visit today: _____

_____

Since your last visit to our office have any of the following occurred:

1. **Were you admitted to the hospital?** ☐ **YES** ☐ **NO** (If **YES**, please explain below)

Facility: _____

Dates of admission: _____

Reason for admission: _____

2. **Had any medical test?** ☐ **YES** ☐ **NO** (If **YES**, please mark any that apply)

TEST	DATE(S)	FACILITY
☐ Mammogram		
☐ Blood work ☐ A1C		
☐ Vision		
☐ MRI ☐ X-ray ☐ CT scan		
☐ DEXA Scan		
☐ Pap smear (women only)		
☐ Colonoscopy		
☐ ECG/EKG		
☐ Other		

3. **Have you seen a specialist?** ☐ **YES** ☐ **NO** (If **YES**, please explain below)

Specialist name: _____

Reason for visit: _____

4. **Have you had any vaccinations?** ☐ **YES** ☐ **NO** (If **YES**, please list below)

_____ _____

_____ _____

Allergies to any medications or food? ☐ Yes or ☐ No (If yes, please list.)

Allergic to the following medications/food	Type of Allergic Reaction
1.	
2.	

List medications you are currently taking:

Medications/Dosage	Medication/Dosage
1.	5.
2.	6.
3.	7.
4.	8.

Pharmacy information:

Name:_____ Phone number:_____

REVIEW OF SYSTEMS

GENERAL
☐ Fever
☐ Night sweats
☐ Chills
☐ Cold intolerance
☐ Fatigue
☐ Daytime drowsiness
☐ Weight gain
☐ Weight loss
☐ Excessive thirst
☐ Excessive hunger
☐ Anorexia

CARDIOVASCULAR
☐ Chest pain
☐ Palpitations
☐ Difficulty breathing at rest
☐ Difficulty breathing with activity
☐ Difficulty breathing when laying down
☐ Shortness of breath
☐ Shortness of breath during sleep
☐ Lower extremity edema
☐ Varicosities

SKIN
☐ Dry hair
☐ Brittle hair
☐ Hair loss
☐ Dry skin
☐ Itching
☐ Hives
☐ Rash
☐ Bruising
☐ New moles
☐ Skin sores
☐ Skin lumps

EYE, EAR, NOSE, MOUTH & THROAT
☐ Change in vision
☐ Loss of vision
☐ Blurred vision
☐ Double vision
☐ Eye redness
☐ Eye pain
☐ Tearing
☐ Purulent discharge
☐ Difficulty hearing
☐ Hearing loss
☐ Ear pain/earache
☐ Tinnitus
☐ Nasal congestion
☐ Nasal discharge
☐ Nosebleed
☐ Sneezing
☐ Snoring
☐ Lip/mouth/tongue sores
☐ Sore throat
☐ Difficulty swallowing
☐ Painful swallowing
☐ Gum bleeding
☐ Dental problems
☐ Hoarse voice
☐ Change in voice quality

GASTROINTESTINAL
☐ Abdominal pain
☐ Rectal pain
☐ Nausea
☐ Vomiting
☐ Vomiting blood
☐ Flatulence
☐ Constipation
☐ Diarrhea
☐ Fecal incontinence
☐ Clay-colored stools
☐ Greasy stools
☐ Tarry stools
☐ Blood in stools
☐ Foul smelling stools

URINARY
☐ Painful urination
☐ Blood in urine
☐ Increased urination
☐ Decreased urination
☐ Increased nighttime urination
☐ Urge symptoms
☐ Urinary incontinence

HEMATOLOGIC
☐ Easy bruising
☐ Difficulty stopping blood flow
☐ Lymph node enlargement
☐ Lymph node tenderness

NEUROLOGICAL
☐ Headaches
☐ Vertigo
☐ Lightheadedness
☐ Fainting
☐ Blackouts
☐ Numbness
☐ Tingling
☐ Tremor
☐ Lack of coordination
☐ Weakness
☐ Difficulty speaking
☐ Memory loss
☐ Difficulty concentrating

GENITAL/REPRODUCTIVE
☐ Changes in libido
☐ Sexual dysfunction
☐ Painful intercourse
☐ Genial discharge

MEN ONLY
☐ Erectile dysfunction

WOMEN ONLY
☐ Breast lump
☐ Breast pain
☐ Nipple discharge
☐ Menorrhagia
☐ Bleeding between periods
☐ Excessive pain with menses
☐ Postmenopausal
☐ Postmenopausal vaginal bleeding
☐ Hot flashes

NECK
☐ Neck pain
☐ Neck stiffness
☐ Neck lumps
☐ Neck swelling

RESPIRATORY
☐ Difficulty breathing
☐ Cough
☐ Cough productive of sputum
☐ Coughing up blood
☐ Wheezing

MUSCULOSKELETAL
☐ Muscle pain
☐ Back pain
☐ Tender joints
☐ Muscle cramps
☐ Muscle weakness
☐ Decreased muscle strength
☐ Limp paralysis
☐ Difficulty walking
☐ Limp

PSYCHIATRIC
☐ Change in mood
☐ Depression
☐ Anxiety
☐ Nervousness
☐ Sleep disturbance
☐ Suicidal ideation
☐ Hopelessness
☐ Worthlessness
☐ Delusions
☐ Hallucinations