INTAKE HISTORY

NAME: _____ DATE: _____

ALLERGIES:

MAJOR ILLNESS	YES	NO	MAJOR ILLNESS	YES	NO
GLAUCOMA			DIABETES		
STROKE			SEIZURES/CONVULSIONS/EPILEPSY		
THYROID DISEASE			FRACTURE		
ASTHMA			BOWEL TROUBLE (CROHN'S/DIVERTICULITIS)		
TUBERCULOSIS			ULCERS		
ANEMIA/BLOOD TRANSFUSION			HEPATITIS/YELLOW JAUNDICE		
BLOOD CLOTS			RHEUMATIC FEVER		
HEART ATTACK/MURMUR/MITRAL VALVE PROLAPSE			KIDNEY INFECTIONS/STONES		
HIGH BLOOD PRESSURE			VENEREAL DISEASE		

MEDICATIONS

OBSTETRICS HISTORY

TOTAL # OF PREGNANCIES:	FULL TERM	PREMATURE	ABORTIONS-INDUCED/SPONTANEOUS	ECTOPICS:	MULTIPLE BIRTHS:	LIVING:

MONTH/YEAR	GESTATIONAL AGE	DELIVERY TYPE	COMPLICATIONS	WEIGHT	SEX

PREVIOUS SURGERIES:

TYPE	DATE	TYPE	DATE

FAMILY HISTORY: HAS ANY BLOOD RELATIVE EVER HAD?

	PLEASE CIRCLE		WHO		PLEASE CIRCLE		WHO
BREAST CANCER	NO	YES		DIABETES	NO	YES	
CERVIX CANCER	NO	YES		OSTEOPOROSIS	NO	YES	
COLON CANCER	NO	YES		ENDOMETRIOSIS	NO	YES	
OVARIAN CANCER	NO	YES		FIBROIDS	NO	YES	
UTERINE CANCER	NO	YES		INFERTILITY	NO	YES	
OTHER CANCER	NO	YES		VON WILLEBRAND	NO	YES	
BLOOD CLOTS	NO	YES		BLEEDING/DISCHARGE	NO	YES	
MISCARRIAGE	NO	YES		CYSTIC FIBROSIS	NO	YES	

SOCIAL HISTORY: PLEASE CIRCLE

SMOKE	NO	YES	
ALCOHOL/DRUGS USE	NO	YES	
DOMESTIC VIOLENCE	NO	YES	
REGULAR EXERCISE	NO	YES	

PREVIOUS ILLNESSES: SYSTEMS REVIEW

	Y	N	Un-sure		Notes
CONST	☐	☐	☐	Weight Loss	
	☐	☐	☐	Weight Gain	
	☐	☐	☐	Fever	
	☐	☐	☐	Fatigue	
EYE	☐	☐	☐	Double Vision	
	☐	☐	☐	Spots before eyes	
	☐	☐	☐	Vision Changes	
EENT	☐	☐	☐	Ear aches	
	☐	☐	☐	Ringing in ears	
	☐	☐	☐	Sinus problems	
	☐	☐	☐	Sore throat	
	☐	☐	☐	Mouth sores	
	☐	☐	☐	Dental problems	
GI	☐	☐	☐	Diarrhea, frequent	
	☐	☐	☐	Bloody stools	
	☐	☐	☐	Nausea/vomiting	
	☐	☐	☐	Constipation	
	☐	☐	☐	Other:	
CARDIO	☐	☐	☐	Painful breathing	
	☐	☐	☐	Chest pain	
	☐	☐	☐	Difficulty breathing on exertion	
	☐	☐	☐	Swelling of legs	
	☐	☐	☐	Palpitations of hear	
RESP	☐	☐	☐	Wheezing	
	☐	☐	☐	Spitting up blood	
	☐	☐	☐	Shortness of breath	
	☐	☐	☐	Cough, chronic	
	☐	☐	☐	Other	
LYMPH	☐	☐	☐	Neck	
	☐	☐	☐	Axillae	
	☐	☐	☐	Groin	
	☐	☐	☐	Other	
MUSCUL	☐	☐	☐	Back Pain	
	☐	☐	☐	Muscle weakness	
	☐	☐	☐	Blood clots	
	☐	☐	☐	Leg Ulcers	
	☐	☐	☐	Other:	

	Y	N	Un-sure		Notes
NEUR	☐	☐	☐	Dizziness	
	☐	☐	☐	Seizures	
	☐	☐	☐	Numbness	
	☐	☐	☐	Trouble Walking	
PS	☐	☐	☐	Depression	
	☐	☐	☐	Crying, frequently	
	☐	☐	☐	Anxiety	
ENDO	☐	☐	☐	Dry Skin	
	☐	☐	☐	Abnormal thirst	
	☐	☐	☐	Hot flashes	
SKIN	☐	☐	☐	Pain in breasts	
	☐	☐	☐	Discharge	
	☐	☐	☐	Masses	
	☐	☐	☐	Rash	
	☐	☐	☐	Ulcer	
GU	☐	☐	☐	Blood in urine	
	☐	☐	☐	Pain with urination	
	☐	☐	☐	Urgency	
	☐	☐	☐	Frequency of urine	
	☐	☐	☐	Incomplete emptying	
	☐	☐	☐	Abnormal periods	
	☐	☐	☐	Painful intercourse	
MENSTRUAL	☐	☐	☐	Vaginal itching	
	☐	☐	☐	Vaginal Burning	
	☐	☐	☐	Birth control method	
	☐	☐	☐	How Long: _____ ERT: Type & # Yrs	
	☐	☐	☐	Length of menses in days: _____	
	☐	☐	☐	Menses how often? _____	
	☐	☐	☐	Spotting between menses	
	☐	☐	☐	Menopause	
OTH	☐	☐	☐	Blood Transfusions	
	☐	☐	☐	Diabetes	
ALL	☐	☐	☐	Allergies	
	☐	☐	☐	Drug, Other	

HISTORY UPDATED AND REVIEWED BY PATIENT

SIGN:		DATE:	
SIGN:		DATE:	