Medical Intake Form

Medical Intake Form

1. Please enter your information.

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Gender:
○ Female ○ Male

Marital Status:
○ Single ○ Married ○ Domestic Partner
○ Separated ○ Divorced ○ Widowed

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone
○ Email

Social Security Number
_____

2. Race (Please check all that apply):

☐ White ☐ Black ☐ Asian
☐ American Indian/Native Alaskan ☐ Native Hawaiian/Pacific Islander ☐ Other

If other, please specify:
_____

3. Ethnicity:

☐ Hispanic/Latino(a) ☐ Not Hispanic/Latino(a)

4. How did you learn about this office? _____ Who referred you? _____

Do you wear glasses or contact lenses?
○ Glasses ○ Contact Lenses ○ Both ○ Neither

5. Emergency Contact: _____ Relationship: _____

Address: _____ City, State & Zip: _____

Phone: Alt. Phone:

6. Family Doctor: Phone:

Other Health Provider: Phone:

Pharmacy: Phone:

7. **Please list individuals (and relationship) with whom you allow us to share your health information:**

	Name	Relationship
1		
2		
3		

8. **Do you have Medical Insurance?**

- ○ Yes
- ○ No
- ○ I don't know

9. **Do you have Vision Insurance?**

- ○ Yes
- ○ No
- ○ I don't know

10. **I authorize the release of any medical information necessary to process my claim and payment of benefits.**

Authorization

Signature Date

What brings you in today?

11. **Problem 1:**

Please describe the issue you're experiencing:

How long have you had this problem?

How severe is this problem?
○ Mild ○ Moderate ○ Severe

Have you tried anything to treat this problem?

12. Problem 2:

Please describe the issue you're experiencing:

How long have you had this problem?

How severe is this problem?
○ Mild ○ Moderate ○ Severe

Have you tried anything to treat this problem?

Review of Systems

Do you have any problems with the following? Please check the correct box:

13. Constitutional

- ☐ Lethargy
- ☐ Fevers/Chills
- ☐ Unexplained weight loss
- ☐ Unexplained weight gain
- ☐ Night Sweats

14. Neurological:

- ☐ Confusion
- ☐ Dizzy/Lightheaded
- ☐ Headaches
- ☐ Memory problems
- ☐ Migraines
- ☐ Neurological Disorder
- ☐ Seizures/Epilepsy

15. Eyes:

- ☐ Blurry Vision
- ☐ Burning
- ☐ Redness
- ☐ Loss of Vision
- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Double Vision

16. Ear/Nose/Throat:

- ☐ Congestion
- ☐ Ear Pain
- ☐ Facial pain/numbness
- ☐ Hoarseness
- ☐ Nose bleeds
- ☐ Sinus pain
- ☐ Ringing in the Ears

17. Respiratory:

- ☐ Blood in Sputum
- ☐ Persistent Coughing
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Asthma/Emphysema

18. Cardiovascular:

- ☐ Angina/Chest Pain
- ☐ Ankle Swelling
- ☐ Exercise Intolerance
- ☐ Heart Palpitation
- ☐ Leg Pain with Walking
- ☐ Wake Short of Breath
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Stroke/TIA
- ☐ Vascular Disease

19. Endocrinology:

- ☐ Type I Diabetes
- ☐ Type II Diabetes
- ☐ High Cholesterol
- ☐ Thyroid Problems

20. Gastrointestinal:

- ☐ Abdominal Pain
- ☐ Blood in Stool
- ☐ Black Stool
- ☐ Bloating
- ☐ Constipation
- ☐ Diarrhea
- ☐ Food Intolerance/Sensitivity
- ☐ Heartburn
- ☐ Nausea/Vomiting
- ☐ Stool Incontinence
- ☐ Bowel Disease
- ☐ Liver Disease

21. Genitourinary:

- ☐ Blood in urine
- ☐ Nighttime urination
- ☐ Heavy/Painful Menses
- ☐ Infertility
- ☐ Impotence
- ☐ Prostate Problems
- ☐ Urine Incontinence
- ☐ Kidney Disease
- ☐ Kidney Stones

22. Allergy/Immunology:

- ☐ Frequent Infections
- ☐ Past Anaphylaxis
- ☐ Seasonal Allergies
- ☐ Swollen Glands
- ☐ Immune Disorder

23. Hematology:

- ☐ Bleed/Bruise Easily
- ☐ Blood Clots
- ☐ Past Blood Transfusion

24. Musculoskeletal:

- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Pain
- ☐ Arthritis
- ☐ Osteoporosis

25. Skin/Breast:

- ☐ Breast Lump
- ☐ Breast Cancer
- ☐ Skin Rash
- ☐ Skin Cancer

26. Psychiatric:

- ☐ Anxiety
- ☐ Depression
- ☐ Disordered Eating
- ☐ Poor Sleep

Medical History

27. Do you currently have or have you ever had

	Yes	No	Past	Location/Type
Cancer	Yes	No	Past	
Implanted Device	Yes	No	Past	
Chronic Pain	Yes	No	Past	

Surgical History

28. Please list your previous surgeries:

	Operation	Month/Year
1		
2		
3		

29. Medications:

	Medication Name	Dosage	Frequency	Reason for taking
1				
2				
3				

30. Allergies? Yes No If yes, please list including reaction:

	Allergy	Reaction
1		
2		
3		

Health

31. Do you:

Smoke?

○ Yes ○ No ○ Past

If past, date quit: _____ Packs/Day: _____ Years: _____

Drink alcohol?
○ Yes ○ No ○ Past

If past, date quit: _____

Have you ever felt a need to cut down on your drinking?
○ Yes ○ No

32. Use recreational drugs?

○ Yes ○ No
○ Past

33. Please list:

_____

Family History

34. Do you have a family (parent, sibling or child) history of:

	Yes	No	If yes, who?
Macular Degeneration	Yes	No	
Heart Disease	Yes	No	
Stroke	Yes	No	
High Blood Pressure	Yes	No	
Diabetes	Yes	No	
Cancer	Yes	No	
Glaucoma	Yes	No	

If with Cancer/Mental Illness, please specify type:

_____

Education/Employment

35. Employment:

○ Full time ○ Part time
○ Retired ○ Not seeking employment
○ Seeking employment ○ Student

36. Occupation:

_____