



## **Patient Health History Intake Form**

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ DOB: \_\_\_\_\_

Reason for you visit today:

---

---

---

### **Personal Medical History**

#### **General Health**

fever  weight loss  weight gain  unusually tired  other (explain)

---

#### **Ear/Nose/Throat**

problem hearing  stuffy nose  earache  sinus pressure  postnasal drip  dizziness

other (explain) \_\_\_\_\_

#### **Heart (Cardiovascular)**

high blood pressure  chest pain  heart attack  high cholesterol

other (explain) \_\_\_\_\_

#### **Lungs (Respiratory)**

Emphysema/COPD  asthma  shortness of breath  cough  wheezing

other (explain) \_\_\_\_\_

#### **Digestion (Gastrointestinal)**

diarrhea  constipation  hiatal hernia  ulcers  acid reflux  indigestion

other (explain) \_\_\_\_\_

#### **Muscles and bones (Musculoskeletal)**

muscle pain/cramps  joint pain  swelling  stiffness  back pain  sciatica

other (explain) \_\_\_\_\_

**Urological**

painful and frequent urination  burning  infection

up at night to urinate (number of times) \_\_\_\_\_

other (explain) \_\_\_\_\_

**Gynecological**

# pregnancies \_\_\_\_\_ #miscarriages \_\_\_\_\_  abortion  D & C

age at onset menstruation \_\_\_\_\_ last period (date) \_\_\_\_\_

other (explain) \_\_\_\_\_

**Breast**

cysts  pain  lumps  biopsy  abnormal mammogram  fibrocystic breast

other (explain) \_\_\_\_\_

**Neurological**

stroke  epilepsy  numbness  weakness  headaches  tremors

other (explain) \_\_\_\_\_

**Psychiatric**

bipolar  depression  anxiety  mood swings  insomnia

other (explain) \_\_\_\_\_

**Blood disorders**

sickle cell disease or trait  anemia

other (explain) \_\_\_\_\_

**Skin**

rash  skin cancer  hair loss  other (explain) \_\_\_\_\_

**Cancer** Type and treatment:

\_\_\_\_\_  
\_\_\_\_\_

**Allergic/Immunologic**

recurrent infections  hay fever  food allergy  drug sensitivity  other (explain)

\_\_\_\_\_

**Endocrine**

diabetes I or II  thyroid problems  low testosterone

menopause (medication?) \_\_\_\_\_

**Please list any hospitalizations**

\_\_\_\_\_  
\_\_\_\_\_

**Surgeries**

wisdom teeth extraction  tonsillectomy  appendectomy  hernia repair  cardiac stent

heart bypass  cataract surgery  gall bladder removal

other (explain) \_\_\_\_\_

**Family History**

Who? Mom, Dad, sibling, grandparent, etc

diabetes  cancer  heart disease  hypertension  arthritis  high cholesterol

other (explain) \_\_\_\_\_

**Personal Social History**

**Marital status**

Married  Divorced  Living w/ partner  Single

**Living arrangements**

# people in household \_\_\_\_\_

**Occupation(s)**

\_\_\_\_\_

**Occupational exposure**

asbestos  printing dye  other (explain) \_\_\_\_\_

**Recent travel (when and where)** \_\_\_\_\_

**Tobacco/Vape**

never  current (#cig/day) \_\_\_\_\_  intermittent (frequency) \_\_\_\_\_

former use (how much used per day & when quit) \_\_\_\_\_

\_\_\_\_\_

**Alcohol**

never  everyday  intermittent (how many/week) \_\_\_\_\_  former

**Recreational drug use**

What kind: \_\_\_\_\_

never  everyday  intermittent  former

**Medications** (list all medications and supplements you are currently taking)

Name	Dose	Frequency	Other Information

**Allergies**

Allergy	Severity	Reaction	Treatment

Preferred Pharmacy \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print name \_\_\_\_\_