Seasons Healthcare

Confidential Patient Intake History

Today's Date: _____________

Name: ___________________________________ SS #: _________________ Birth date: _____________
Address: ____
City: _________________________________ State: _____________ Zip: _______________
Telephone: _________________ (Home) ____________________ (Work) ___________________ (Cell)
Gender: ___ Male ___ Female E-Mail Address: ____________________________________

Occupation: _________________________________ Employer: _________________________________
Marital Status: ___________________ Name of Spouse/Partner: ______________________________
Referred by: ____

Emergency Contact: ______________________________________ Relationship: ___________________
Home Telephone: ______________________ Work Telephone: ____________________

Why have you come to the office today? ____
Please describe your problem, including where it is, how severe it is, and how long it's lasted: ________
____
____

Allergies: Please check all that apply.

___ Penicillin ___ Morphine ___ Dye Allergies ___ Pet Allergies
___ Codeine ___ Aspirin ___ Nitrate Allergy ___ Seasonal Allergy
___ Sulfa Drug ___ Food Allergies ___ No Known Drug Allergies
Other: _______________________

Please describe the allergic reaction you experienced and when it occurred?
____
____

Current Prescription Medications: ___ currently **not** taking any medication

Medication Name	Strength	How often per day?	Date Started

Over-the-counter (OTC) issues:
Please check all products that you use occasionally or regularly. Check all that apply.

___ Pain Reliever
___ Aspirin
___ Acetaminophen (Ex: Tylenol)
___ Ibuprofen (Ex: Motrin)
___ Naproxen (Ex: Aleve)
___ Ketoprofen (Ex: Orudis KT)
___ Cough Suppressant (Ex: Robitussin DM)
___ Antihistamine Product (Ex: Chlor-Trimeton)
___ Decongestant Product (Ex: Sudafed)
___ Combination Product (Cough+Cold Reliever) (Ex: Triaminic DM.)
___ Sleep Aids (Ex: Excedrin PC, Unisom, Sominex, Nytol)
___ Antidiarrheals (Ex: Imodium, Pepto Bismol, Kaopectate)
___ Laxatives/Stool Softeners (Ex: Doxidan, Correctol, etc.)
___ Diet Aids/Weight Loss Products (Ex: Dexatril)
___ Antacids (Ex: Maalox. Mylanta)
___ Acid Blockers (Ex: Tagamet HB, Pepcid C, Zantac 75)
___ Other (Please list) ________________________________

Nutritional/Natural Supplements: Please identify and list the products you are using.

___ Vitamins (Ex. Multiple or simple vitamins such as B complex, E, C, Beta Carotene)
___ Minerals (Ex: Calcium, Magnesium, Chromium, Colloidal Minerals, Various Single Minerals.)
___ Herbs (Ex: Ginseng, Ginkgo Biloba, Echinacea, Other Herbal Medicinal Teas, Tinctures,etc.)
___ Enzymes (Ex: Digestive formulas, Papaya, Bromelain, CoEnzyme Q10, etc.)
___ Nutrition/Protein Supplements (Ex: Shark Cartilage, Protein Powers, Amino Acids, Fish Oils)
___ Others (Ex: Glucosamine, etc.)

Medical Conditions/Diseases: Please check all that apply to **you**.

___ Heart Disease (Ex. Congestive Heart Failure)
___ High Cholesterol or Lipids (Ex: Hyperlipidemia)
___ High Blood Pressure (Ex: Hypertension)
___ Cancer *Type:* _______________________
___ Ulcers (Stomach, Esophagus)
___ Thyroid Disease
___ Hormonal Related Issues
___ Lung Condition (Ex: Asthma, Emphysema, COPD)
___ Blood Clotting Problems
___ Diabetes
___ Arthritis or Joint Problems
___ Depression
___ Epilepsy
___ Headaches/Migraines
___ Eye Disease (Glaucoma, etc)
___ Other :(Please list) _________________

Family History: Please check all that apply & list which relative(s):

___ Heart Disease (Ex. Congestive Heart Failure) ____________________________________
___ High Blood Pressure (Ex: Hypertension) ____________________________________
___ High Cholesterol or Lipids (Ex: Hyperlipidemia) ____________________________________
___ Diabetes ____________________________________
___ Lung Condition (Ex: Asthma, Emphysema, COPD) ____________________________________
___ Blood Clotting Problems ____________________________________
___ Ulcers (Stomach, Esophagus) ____________________________________
___ Cancer ____________________________________
___ Depression ____________________________________
___ Thyroid Disease ____________________________________
___ Headaches/Migraines ____________________________________
___ Other: ____________________________________

Social History: How often and how much?

Do you use tobacco?	___ Yes	___ No	_____________________________
Do you use alcohol?	___ Yes	___ No	_____________________________
Do you use caffeine?	___ Yes	___ No	_____________________________
Do you use a seat belt?	___ Yes	___ No	_____________________________
Do you exercise regularly?	___ Yes	___ No	_____________________________

Surgical History/Hospitalization: Date

____
____
____
____

Patient Name: ______________________

Review of Systems

Physician's Notes

Constitutional

Weight Loss	___ Now	___ Past	___ Not Sure	__________________________
Weight Gain	___ Now	___ Past	___ Not Sure	__________________________
Fever	___ Now	___ Past	___ Not Sure	__________________________
Fatigue	___ Now	___ Past	___ Not Sure	__________________________
Change in Height	___ Now	___ Past	___ Not Sure	__________________________

Eyes

Double Vision	___ Now	___ Past	___ Not Sure	__________________________
Spots Before Eyes	___ Now	___ Past	___ Not Sure	__________________________
Vision Changes	___ Now	___ Past	___ Not Sure	__________________________
Glasses/Contacts	___ Now	___ Past	___ Not Sure	__________________________

Ear, Nose, and Throat

Earaches	___ Now	___ Past	___ Not Sure	__________________________
Ringing in Ears	___ Now	___ Past	___ Not Sure	__________________________
Sinus Problems	___ Now	___ Past	___ Not Sure	__________________________
Sore Throat	___ Now	___ Past	___ Not Sure	__________________________
Mouth Sores	___ Now	___ Past	___ Not Sure	__________________________
Dental Problems	___ Now	___ Past	___ Not Sure	__________________________

Cardiovascular

Painful Breathing	___ Now	___ Past	___ Not Sure	__________________________
Chest Pain/Pressure	___ Now	___ Past	___ Not Sure	__________________________
Difficulty Breathing on Exertion	___ Now	___ Past	___ Not Sure	__________________________
Swelling of Legs	___ Now	___ Past	___ Not Sure	__________________________
Rapid or Irregular Heartbeat	___ Now	___ Past	___ Not Sure	__________________________

Respiratory

Wheezing	___ Now	___ Past	___ Not Sure	__________________________
Spitting up Blood	___ Now	___ Past	___ Not Sure	__________________________
Shortness of Breath	___ Now	___ Past	___ Not Sure	__________________________
Chronic Cough	___ Now	___ Past	___ Not Sure	__________________________

Gastrointestinal

Frequent Diarrhea	___ Now	___ Past	___ Not Sure	__________________________
Bloody Stool	___ Now	___ Past	___ Not Sure	__________________________
Nausea/Vomiting/Indigestion	___ Now	___ Past	___ Not Sure	__________________________
Constipation	___ Now	___ Past	___ Not Sure	__________________________
Involuntary Loss of Gas or Stool	___ Now	___ Past	___ Not Sure	__________________________

Neurologic

Dizziness	___ Now	___ Past	___ Not Sure	__________________________

Seizures ___ Now ___ Past ___ Not Sure ________________________
Numbness ___ Now ___ Past ___ Not Sure ________________________
Trouble Walking ___ Now ___ Past ___ Not Sure ________________________
Severe Memory Problems ___ Now ___ Past ___ Not Sure ________________________
Frequent/ Severe Headaches ___ Now ___ Past ___ Not Sure ________________________

Patient Name: _____________________

Genitourinary

Blood in Urine ___ Now ___ Past ___ Not Sure ________________________
Pain with Urination ___ Now ___ Past ___ Not Sure ________________________
Strong Urgency to Urinate ___ Now ___ Past ___ Not Sure ________________________
Frequent Urination ___ Now ___ Past ___ Not Sure ________________________
Incomplete Emptying ___ Now ___ Past ___ Not Sure ________________________
Involuntary Urine Loss ___ Now ___ Past ___ Not Sure ________________________
Urine loss when Coughing/Lifting ___ Now ___ Past ___ Not Sure ________________________
Abnormal Bleeding ___ Now ___ Past ___ Not Sure ________________________
Painful Periods ___ Now ___ Past ___ Not Sure ________________________
Premenstrual Syndrome (PMS) ___ Now ___ Past ___ Not Sure ________________________
Painful Intercourse ___ Now ___ Past ___ Not Sure ________________________
Fibroids ___ Now ___ Past ___ Not Sure ________________________
Infertility ___ Now ___ Past ___ Not Sure ________________________
Des Exposure ___ Now ___ Past ___ Not Sure ________________________
Abnormal Vaginal Discharge___ Now ___ Past ___ Not Sure ________________________

Skin

Rash ___ Now ___ Past ___ Not Sure ________________________
Sores ___ Now ___ Past ___ Not Sure ________________________
Dry Skin ___ Now ___ Past ___ Not Sure ________________________
Moles ___ Now ___ Past ___ Not Sure ________________________

Breast

Pain in Breast ___ Now ___ Past ___ Not Sure ________________________
Nipple Discharge ___ Now ___ Past ___ Not Sure ________________________
Lumps ___ Now ___ Past ___ Not Sure ________________________

Musculoskeletal

Muscle Weakness ___ Now ___ Past ___ Not Sure ________________________
Muscle or Joint Pain ___ Now ___ Past ___ Not Sure ________________________

Psychiatric

Depression/Frequent Crying___ Now ___ Past ___ Not Sure ________________________
Severe Anxiety ___ Now ___ Past ___ Not Sure ________________________

Endocrine

Hair Loss ___ Now ___ Past ___ Not Sure ________________________
Heat/Cold Intolerance ___ Now ___ Past ___ Not Sure ________________________
Abnormal Thirst ___ Now ___ Past ___ Not Sure ________________________
Hot Flashes ___ Now ___ Past ___ Not Sure ________________________

Hematologic/Lymphatic

Frequent Bruises	___ Now	___ Past	___ Not Sure	_________________________
Cuts Do Not Stop Bleeding	___ Now	___ Past	___ Not Sure	_________________________
Enlarged Lymph Nodes	___ Now	___ Past	___ Not Sure	_________________________

Form Completed by: ___ Patient ___ Nurse ___ Physician ___ Other

Print Name: ____

Signature of Patient: ____