Adult Intake Form

(age 13 and up) Patient: DOB: Date:

Who referred you to our clinic? _____

Reason for today's encounter? _____

When did it begin? _____ Severity? _____

What makes it better? _____ What makes it worse? _____

Have you had imaging/biopsy? _____ Other symptoms? _____

Allergies to medications: _____

Any other allergies (latex, contrast, shellfish, anesthesia reaction): _____

Medications *Please list or provide list.*

_____

Past Medical History *Have you ever had problems in any of the following categories? If yes, please specify.*

Cancer: ○ No ○ Yes, What type and when? _____

Endocrine (Diabetes, low thyroid, etc): ○ No ○ Yes: _____

Gastrointestinal (Acid reflux, stomach ulcer): ○ No ○ Yes: _____

Heart (Heart attack, heart failure, coronary artery dis, heart valve): ○ No ○ Yes: _____

Vascular (High blood pressure, aortic aneurysm, carotid stenosis): ○ No ○ Yes: _____

Blood (Bleeding disorder, clotting disorder, anemia): ○ No ○ Yes: _____

Infectious (HIV, tuberculosis, hep C): ○ No ○ Yes: _____

Kidney (Kidney disease, kidney stone): ○ No ○ Yes: _____

Liver (Liver failure, hepatitis): ○ No ○ Yes: _____

Lung (Asthma, sleep apnea, emphysema/COPD, pneumonia): ○ No ○ Yes: _____

Neurologic (Stroke, seizure, headache, chronic pain, anxiety, depression, dementia): ○ No ○ Yes: _____

Other: _____

Are you pregnant? ○ NA ○ No ○ Yes

Past Surgical History *Please list surgeries you have had with approximate year.*

_____

Family History *Please list any problems (especially those listed above) that family members have had.*

_____

Social History	*Do you or have you...*	*How much?*	*How often?*	*If formerly, when did you quit?*
Smoke/d	○ No ○ Yes ○ Formerly			
Chew/ed tobacco	○ No ○ Yes ○ Formerly			
Consume/d alcohol	○ No ○ Yes ○ Formerly			
Use/d recreational drugs	○ No ○ Yes ○ Formerly			

Occupation? _____ *Married?* ○ No ○ Yes

Review of Systems *Please check below if you have any of the following:*

Constitutional
- ☐ Fever
- ☐ Weight loss

Eyes
- ☐ Changes in vision

HENT
- ☐ Nasal blockage ☐ Right ☐ Left
- ☐ Facial or sinus pain ☐ Right ☐ Left
- ☐ Nasal drainage
- ☐ Nose bleeds ☐ Right ☐ Left
- ☐ Loss of smell/taste
- ☐ Hearing loss ☐ Right ☐ Left
- ☐ Ear ringing ☐ Right ☐ Left
- ☐ Ear Pain/fullness
- ☐ Ear drainage
- ☐ Throat pain
- ☐ Difficulty swallowing
- ☐ Hoarseness

Cardiovascular
- ☐ Chest pain

Respiratory
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Snoring
- ☐ Sleep apnea
- ☐ Nighttime awakenings
- ☐ Daytime sleepiness

Gastrointestinal
- ☐ Vomiting
- ☐ Heartburn or reflux

Neurologic
- ☐ Dizziness
- ☐ Headaches

Musculoskeletal
- ☐ Joint, muscle or back pain

Psychiatric
- ☐ Anxiety
- ☐ Depression

Heme-Lymph
- ☐ Easy bleeding or bruising

Allergy
- ☐ Sneezing
- ☐ Itching
- ☐ Seasonal allergies