NURSING INTAKE FORM

Patient Name_____ **Date of Birth**_____ **Date**_____

Reason for your visit_____

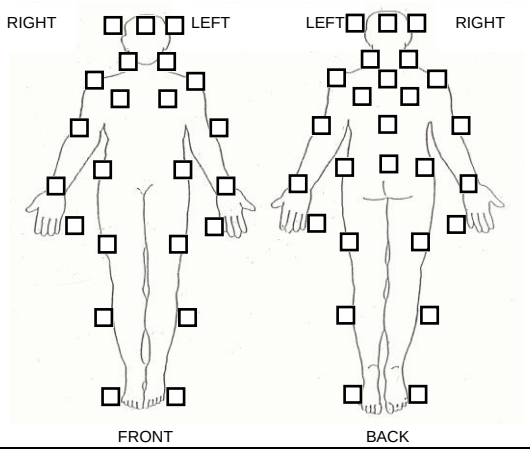
Referring M.D._____ Primary Care M.D._____

Height_____ Weight_____ ○Right handed or ○Left handed

(For office use only)
BP_____ BMI_____ Growth chart (if applicable)_____

Date of last flu vaccination_____ **Date of last pneumonia vaccination**_____
Do you smoke? ○No ○Yes (amount per day)_____
Do you use tobacco in any other form? ○No ○Yes *If yes, ○cigars ○smokeless
How many years have you used tobacco?_____
Do you drink caffeine? ○No ○Yes (amount)_____
Do you drink alcohol? ○No ○Yes (amount per day)_____

AREAS OF PAIN
Click All That Apply On Drawing



Please select your current level of pain:
(0= No pain and 10= Unbearable pain)

0

Family Medical History: (Please include for your mother, father, and siblings.)

_____

_____

Social History:

Marital status:_____ Children:_____

Occupation:_____

Level of education:_____

Past Medical History: (Please check all that apply.)

- ☐ Anemia
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bleeding disorder
- ☐ Blood clots
- ☐ Cancer
- ☐ Type:_____
- ☐ Cataracts
- ☐ Congestive heart failure
- ☐ Diabetes
- ☐ Dialysis
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Heart valve
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hypothyroidism
- ☐ Kidney failure
- ☐ Migraines
- ☐ Parkinson's
- ☐ Peptic ulcer disease
- ☐ Reflux
- ☐ Seizures
- ☐ Sleep disorder
- ☐ Stroke
- ☐ TIA

Other_____

Past Surgical History: (Please check all that apply.)

- ☐ Amputation
- ☐ Back surgery
- ☐ Breast surgery
- ☐ CABG (bypass)
- ☐ Carotid surgery
- ☐ Carpal tunnel
- ☐ Cataract
- ☐ C-Section
- ☐ Cholecystectomy (gallbladder)
- ☐ Gastric bypass
- ☐ Hip Replacement
- ☐ Knee (scope)
- ☐ Knee replacement
- ☐ Lumpectomy
- ☐ Mastectomy
- ☐ Mitral valve
- ☐ Neck surgery
- ☐ Pacemaker
- ☐ Shoulder
- ☐ Sinus
- ☐ TAH (hysterectomy)
- ☐ Thyroid
- ☐ Tonsillectomy
- ☐ Tubal ligation

Other_____

Current Medications: (Please include dosage and how often you take the medication.)

_____

_____

_____

Pharmacy Name/Address: _____

Pharmacy Phone Number:_____

Allergies/Reactions: (Please include medication, food and environmental allergies.)

_____

Seafood allergy? ◯ No ◯ Yes Latex allergy? ◯ No ◯ Yes

Review of Systems: **(Please check symptoms that you are currently experiencing.)**

General
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Anorexia
- ☐ Fatigue/weakness
- ☐ Malaise
- ☐ Weight loss
- ☐ Sleep Disorder

Eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ Eye irritation
- ☐ Drainage from your eyes
- ☐ Vision loss
- ☐ Eye pain
- ☐ Sensitivity to light

ENT
- ☐ Earache
- ☐ Ear drainage
- ☐ Ringing in your ears
- ☐ Decreased hearing
- ☐ Nasal congestion
- ☐ Nose bleeds
- ☐ Sore throat
- ☐ Hoarseness

CV
- ☐ Chest pains/palpitations
- ☐ Passing out
- ☐ Trouble breathing w/ activity
- ☐ Trouble breathing unless standing
- ☐ Waking up at night unable to breathe
- ☐ Swelling in your feet

Resp
- ☐ Cough
- ☐ Trouble breathing at rest
- ☐ Excessive sputum/phlegm
- ☐ Coughing up blood
- ☐ Wheezing
- ☐ Pleurisy

GI
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Change in bowel habits
- ☐ Abdominal pain
- ☐ Blood in your stool
- ☐ Jaundice/yellowing of your skin
- ☐ Gas/Bloating
- ☐ Indigestion/heartburn
- ☐ Trouble swallowing

GU
- ☐ Loss of control of bladder
- ☐ Trouble urinating
- ☐ Urinary frequency
- ☐ Pelvic pain

MS
- ☐ Back pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle cramps
- ☐ Muscle weakness
- ☐ Muscle stiffness
- ☐ Arthritis
- ☐ Sciatica
- ☐ Restless legs
- ☐ Leg pain at night/with activity

Derm
- ☐ Rash/itching/dryness to skin
- ☐ Suspicious lesions on skin

Neuro
- ☐ Paralysis
- ☐ Tingling
- ☐ Numbness
- ☐ Seizures
- ☐ Tremors
- ☐ Vertigo
- ☐ Episodes of blindness
- ☐ Frequent falls
- ☐ Frequent headaches
- ☐ Difficulty walking

Psych
- ☐ Depression
- ☐ Anxiety
- ☐ Memory loss
- ☐ Suicidal thoughts
- ☐ Hallucinations
- ☐ Paranoia/phobia
- ☐ Confusion

Endo
- ☐ Cold/heat intolerance
- ☐ Excessive thirst/hunger
- ☐ Frequent urination
- ☐ Unusual weight change

Heme
- ☐ Abnormal bruising/bleeding
- ☐ Enlarged lymph nodes

Allergy
- ☐ Itching or rash to skin
- ☐ Hay fever
- ☐ Recurrent infections

-or- ☐ You are currently not experiencing any symptoms.

PRINT PACKET & BRING TO APPOINTMENT