



INTAKE SHEET

Patient's Name _____ D.O.B. _____

Reason for Appointment _____ Allergies _____

Past History:

_____ childhood diseases _____ rheumatic fever
 _____ diabetes _____ TB
 _____ other _____

Previous Surgeries:

Date	Type
_____	_____
_____	_____
_____	_____

Family History:

mother _____ living _____ dead _____ age _____
 father _____ living _____ dead _____ age _____
 sister _____ living _____ dead _____ age _____
 brother _____ living _____ dead _____ age _____

Cause of Death:

*Any family members with a history of: _____ cancer
 _____ diabetes
 _____ TB
 _____ heart disease

Social History:

married _____ single _____ divorced _____ widowed _____ occupation _____
 spouse's name _____
 children: # males _____ ages _____ ; # females _____ ages _____

Smokes: _____ yes _____ no **Alcohol Intake:** _____ yes _____ no

How much? _____ How much? _____
 How long? _____ Quit? _____

Current Medications:	Name	Dose	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Review of Systems:

Y	N		Y	N		Y	N	
_____	_____	headaches	_____	_____	gastrointestinal	_____	_____	menopause (age) jt/backpain fevers chills noc sweats unusual swelling
_____	_____	visual problems	_____	_____	_____*	_____	_____	
_____	_____	extremity weakness	_____	_____	abdominal pain	_____	_____	
_____	_____	lung problems	_____	_____	jaundice	_____	_____	
_____	_____	_____*	_____	_____	gallstones	_____	_____	
_____	_____	SOB	_____	_____	nausea	_____	_____	
_____	_____	cough	_____	_____	vomiting	_____	_____	
_____	_____	sputum	_____	_____	diarrhea	_____	_____	
_____	_____	heart problems	_____	_____	constipation	_____	_____	
_____	_____	_____*	_____	_____	urinary problems	_____	_____	
_____	_____	chest pain	_____	_____	_____*	_____	_____	
_____	_____	palpitations	_____	_____	frequency	_____	_____	
_____	_____		_____	_____	urgency	_____	_____	
_____	_____		_____	_____	nocturia	_____	_____	
_____	_____		_____	_____	dysuria	_____	_____	

*Other medical problems

T: _____ BP: _____
 P: _____
 R: _____ HE: _____ WT: _____

*Advanced Directive

Previous Chemo Tx: _____
 Previous Radiation Tx: _____
 Access: _____
 Referring Physician: _____

*Advanced Directive