Patient History Intake Form

Date:_____Patient Name_____

Reason for today's visit_____

Drug Allergies? ___ Yes ___No

If yes please list: _____ _____

_____ _____

List current Medications: _____ _____

_____ _____

_____ _____

Surgeries? ____Yes ____No

If yes please list: _____ _____

_____ _____

_____ _____

Any Reaction to IV Contrast? ____Yes _____No _____N/A

Pacemaker or Defibrillator? ____Yes _____No **Heart Stents?** ____ Yes _____No

Do you smoke or have a history of smoking? ___Yes ___No

Are you on a daily Aspirin regimen? _____Yes ____No

Your Current Pharmacy Name & Location:

_____

Please indicate if there is a family history of the following:

____Bladder Cancer

____Breast Cancer

____Prostate Cancer

____Testicular Cancer

____Renal (kidney) Cancer

REVIEW OF SYSTEMS

Do you now or have you had any problems related to the following systems?
Please circle: Yes or No

Constitutional
Fever Y N
Chills Y N
Headaches Y N
Other _____

Eyes
Blurred vision Y N
Double vision Y N
Pain Y N
Other _____

Allergic/Immunologic
Hay Fever Y N
Drug Allergies Y N

Other _____

Neurological
Tremors Y N
Dizzy spells Y N
Numbness/
tingling Y N
Other _____

Endocrine
Excessive Thirst Y N
Too hot/cold Y N
Tired/sluggish Y N
Other _____

Gastrointestinal
Abdominal Pain Y N
Nausea/vomiting Y N
Indigestion Y N
Heartburn Y N
Other _____

Cardiovascular
Chest Pain Y N
Varicose veins Y N
High BP Y N
Other _____

Physician Comments:

Integumentary
Skin rash Y N
Boils Y N
Persistent Itch Y N
Other _____

Musculoskeletal
Joint Pain Y N
Neck pain Y N
Back Pain Y N
Other _____

Ear/Nose/Throat/Mouth
Ear Infection Y N
Sore Throat Y N
Sinus Problems Y N
Other _____

Genitourinary
Urine retention Y N
Painful urination Y N
Urinary frequency Y N

Other _____

Respiratory
Wheezing Y N
Frequent Cough Y N
Short of Breath Y N
Order _____

Hematologic / Lymphatic
Swollen Glands Y N
Blood clotting Y N

Other _____

Psychologic
Are you generally satisfied with your
Life? Y N
Do you feel Depressed?
Y N
Have you considered suicide
Y N

# of Answers	Level of Service
0-1	1 or 2
2-9	3
10+	4 or 5