

Patient Intake Form**Patient Name** _____ **Visit Date** _____**Phone** (home) _____ (work) _____ (cell) _____**E-mail address:** _____May we leave personal/private messages for you on your voicemail? yes noEmail? yes no**Marital Status:** _____ with whom do you live?
_____**DOB** ___/___/___ **Age** _____ Are you currently employed: No Yes Retired **Current or former occupation:**
_____**Referring physician (name and phone number):**
_____**Primary Care Physician (name and phone number):**
_____Other physicians you would like us to keep informed (name and phone number):
_____**Reason for visit:**
_____**Medical Information:**

Height: _____ Weight: _____ Recent weight loss? _____ pounds _____ months

Do you have pain? _____

Do you smoke now? No Yes Did you smoke in the past? No Yes

When did you stop? _____ How many packs per day? _____ How many years? _____

About how much alcohol do you drink? None Occasionally 1 drink/day 2-3 drinks/day More than 3 drinks/day Have you ever been treated for drug/alcohol addiction? No Yes **Drug Allergies** No Yes Please list:

Medication List:

Current Medications:	For the Treatment of:	Dose	How Often?

Major Medical Problems (diabetes, heart, lung, blood pressure, scleroderma, connective tissue disorder):

Prior Surgeries & Dates:

Hospitalizations & Dates:

Previous radiation treatment? No Yes When/Where?

Previous or current chemotherapy? No Yes When/Where?

History of cancer in the family:

Pharmacy: _____ **Phone:** _____

Do you have an implanted medical device including, but not limited to, pacemakers, defibrillators, neurostimulators, drug infusion pumps or prostheses? No Yes Please list type and manufacturer:

*We do not release information about you without your consent. If you wish to give us permission to speak freely with certain relatives or friends, please list their names and relationship to you.

Emergency Contact(s): Name, Relation, and Phone Number

Review of Systems

Are you currently experiencing or have you experienced any of the following symptoms **within the last 30 days?**

	Yes	NO		Yes	NO
Constitutional			Reproductive-Female		
Appetite change			Breast lumps		
Fatigue			Nipple discharge		
Fever			Estrogen Replacement (current or previous) – Years _____		
Weight Loss			Last menstrual period /		
Eyes			Age when periods began		
Eye Discharge			Number of pregnancies:		
Eye Pain			Number of live births:		
Head/Ears/Nose/Throat			Age at 1 st birth:		
Hearing loss			Musculoskeletal		
Pain in ears			Joint Pain/arthritis		
Ringing in ears			Back Pain		
Nose bleeds			Problems walking		
Congestion			Joint Swelling		
Dental problem			Skin		
Sore Throat			Rash		
Trouble swallowing			Wound		
Voice change			Neurologic		
Respiratory			Dizziness		
Chronic cough			Headaches		
Difficulty breathing			Numbness		
Wheezing			Seizures		
Cardiovascular			Speech difficulty		
Chest pain			Fainting		
Leg Swelling			Weakness in arms or legs		
Palpitations			Hematologic		
Pacemaker			Swollen lymph nodes		
Gastrointestinal			Bruises/Bleed easily		
Abdominal pain			Immunology		
Blood in stools			Rheumatoid arthritis		
Constipation			Lupus		
Diarrhea			Scleroderma		
Nausea			Psychiatric		
Vomiting			Agitation		
Genitourinary			Confusion		
Difficulty urinating			Depressed mood		
Burning upon urination			Nervous/Anxiety		
Frequent urination					
Blood in urine					
Urgency					
Sexual activity					