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NEW PATIENT INTAKE FORM

DATE OF APPOINTMENT_____

NAME_____ **AGE**_____

REASON(S) FOR THIS CONSULTATION_____
_____
_____

ALLERGIES
medications_____ foods_____ other _____

CURRENT MEDICATIONS (INCLUDE ALL OVER-THE-COUNTER MEDS AND DOSAGES, SUPPLEMENTS, HERBS)
_____ _____ _____
_____ _____ _____
_____ _____ _____

MEDICAL HISTORY--PLEASE *CIRCLE* ALL THAT APPLY (INCLUDE CURRENT AND PAST CONDITIONS)

●acid reflux	●irritable bowel	●stomach ulcers	●anemia (cause)_____
●high blood pressure	●high cholesterol	●bleeding problems	●blood clots (age, cause)_____
●asthma	●osteoporosis/-penia	●heart murmur	●blood transfusion (year)_____
●arthritis	●eye disease	●lupus	●peripheral vascular occlusive disease (PVOD--poor arterial circulation)
●thyroid problems	●kidney stones	●colon polyps	
●diabetes (adult or juvenile onset)	●cancer (type, tx) _____	●hepatitis (A, B, or C)	●heart disease (include heart attacks, angiograms, stents, arrhythmia)
●alcohol/drug abuse		●stroke (age/cause)___ _____	_____
●neurologic disorders (multiple sclerosis, Parkinson's)	●pinched nerve/sciatica	●migraine headaches	●seizure disorder
	●depression/anxiety	●eating disorder	●enlarged prostate
	●kidney failure	●interstitial cystitis	●skin problems_____

OTHERS/EXPLAIN IN FURTHER DETAIL_____
_____

OPERATIONS AND HOSPITALIZATIONS

1._____AGE_____	4._____AGE_____
2._____AGE_____	5._____AGE_____
3._____AGE_____	6._____AGE_____

FAMILY HISTORY (LIST BLOOD RELATIVES WITH SIGNIFICANT DIAGNOSES)

●heart attack_____age of onset_____
●stroke_____ cause_____
●alcohol/drug abuse_____
●diabetes_____ (adult or juvenile onset)
● premature natural or surgical menopause in mother/sister/or other female relative?_____
●high blood pressure_____ age of onset_____
●blood clots_____cause_____
●depression/anxiety_____
●high cholesterol_____
●other_____
●cancer_____ type_____

SOCIAL HISTORY
occupation_____☐ single ☐ married # biological children_____ alcohol use (amount per day/week)_____
Do you or have you smoked consistently?_____Packs per day_____what ages_____

OB/GYN HISTORY (FOR WOMEN PATIENTS ONLY)
●1st day of last menstrual cycle_____ ● if menopausal, age of last natural menstrual cycle_____
●age of onset of menses_____ ●typical cycle is every _____days with _____days of bleeding or _____
●total # pregnancies_____●miscarriages_____ ●abortions_____ ●infertility history_____ treatment_____
●use of birth control pills/rings/patches (or any other method of hormone manipulations)_____what ages_____
●current method of birth control_____ ●history of uterine fibroids/ovarian cysts/or fibrocystic breasts?_____
●# of steady sex partners_____ ●history of venereal disease?_____ treatment_____
●previous abnormal PAP smears?_____ pathology type and treatment_____
●previous or current use of HRT?_____type_____ages_____

(QUESTIONS CONTINUED ON BACK SIDE)

REVIEW OF SYMPTOMS (CIRCLE ALL THAT APPLY TO YOU):

●achy joints	●palpitations	●chest pain	●allergies (itchy, sneezy, runny, and/or stuffy)
●constipation	●heartburn	●abdominal pain	●difficulty with swallowing
●diarrhea	●nausea	●vomiting	●unexpected significant weight gain/loss
●loss of appetite	●night sweats	●hemorrhoids	●need to urinate during sleep _____# times/night
●shortness of breath	●persistent fatigue	●insomnia/poor sleep	●poor exercise tolerance
●low sex drive	●blood in stools	●blood in urine	●frequent urinary tract infections
●low back pain	●painful urination	●urinary incontinence	●difficulty with erections
●neck pain	●headaches/migraines	●skin/nail problems	●cold hands and/or feet
●dizziness	●memory loss	●hearing loss	●vaginal itching/discharge
●dry eyes	●restless legs	●anxiety/depression	●recurrent yeast infections
●swollen glands	●varicose veins	●hot flashes	●bleeding between menstrual cycles
●dry skin	●hair loss	●pain with sex	●bleeding with sex
●lumpy breasts	●nipple discharge	●acne	●pelvic pain (not necessarily with sex)

other(s)--please explain_____
_____

PREVIOUS NOTABLE TEST RESULTS (PLEASE BRING ACTUAL COPIES IN FOR DR. CHEN IF AVAILABLE):

●date of last PAP_____ result_____
●date of last mammogram/breast ultrasound_____ result_____
●date of last colonoscopy_____ result_____
●date of last pelvic ultrasound_____result_____
●date of last bone density scan _____results (include T-scores in hip and spine)_____
●please also bring in copies of other significant tests done previously, including endoscopies, ultrasounds, CAT scans, carotid doppler of the neck, echocardiograms, MRI, MRA, upper/lower GI series, etc.
●please also bring in copies of previous lab test results, including cholesterol panel, hormone testing, PSA, thyroid tests, biopsy results, CRP, vitamin levels, etc.

PHYSICAL EXAM: BP_____ PULSE_____ WEIGHT_____(LBS.) HEIGHT_____
HEENT—nl or _____ Neck—nl or _____
Lungs—nl or _____ CV—nl or _____ Abd—nl or _____
Ext.—nl or _____ Others_____
_____