

PATIENT INTAKE FORM

(Please be sure to fill out all 3 pages of this form.)

Social History:

Tobacco _____ Current / Everyday _____ Former Years _____
 _____ Current / Some Days _____ Never Packs _____

Alcohol _____ Current / Everyday _____ Former Amount _____
 _____ Current / Some Days _____ Never

Status Single Married Divorced Widowed

Review of Systems:

1. Are you having fatigue? _____ Yes _____ No

2. Have you had recent weight _____ gain _____ loss? If so, how much? _____

3. Are you having headaches? If so, describe: _____ Yes _____ No

4. Are you having an earache? _____ Yes _____ No

5. Do you have hearing loss? _____ Yes _____ No

6. Visual problems not connected with glasses? _____ Yes _____ No

7. Sinus congestion or postnasal drip? _____ Yes _____ No

8. Have you been told you: _____ Snore _____ Stop breathing ... during sleep? _____ Yes _____ No

9. Have trouble getting to sleep? _____ Yes _____ No

10. Feel rested in the morning? _____ Yes _____ No

11. Excessive daytime sleepiness? _____ Yes _____ No

12. Shortness of breath? If so, (check) _____ at rest _____ with activity _____ both _____ Yes _____ No

13. Do you wheeze? _____ Yes _____ No

14. Do you cough? _____ Yes _____ No

 If so, are you coughing up anything? _____ Yes _____ No

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Review of Systems (cont'd):

15. Do you have palpitations? Yes No
16. Do you have chest pain? Yes No
17. If so, how long does each episode last? _____ with (check) Rest Activity Both
18. Is the chest pain associated with (check): Nausea Sweating Shortness of breath
19. Does the chest pain radiate: across chest down arm up neck Yes No
20. Do you have diarrhea? Yes No
21. Do you have constipation? Yes No
22. Do you have blood in stool or dark black stool? Yes No
23. Do you have abdominal pain? Yes No
24. Do you have reflux of stomach / indigestion? Yes No
25. Do you have blood in your urine? Yes No
26. Pain or burning with urination? Yes No
27. Do you have loss of bladder control? Yes No
28. Any muscle or joint aches? Yes No
29. Any numbness or weakness in arm or leg? Yes No
30. Any anxiety or depression? Yes No

Anything else you would like for us to know about your health: