INITIAL VISIT PATIENT INTAKE FORM
(Page 1 of 4)

Date of Visit: _____

Name: _____ **Date of Birth: _____**

Race: __American Indian or Alaskan Native __Asian __Black or African-American __More Than One Race __Native Hawaiian __Other Pacific Islander __White __Refused to Report/Unreported

Ethnicity: __Hispanic or Latino __Non-Hispanic or Latino __Refused to Report/Unreported

Language: __English __Spanish __Other: _____

REASON FOR COMING TO THE DOCTOR TODAY:

Reason for Today's Visit: _____

Timing/Onset: When did symptoms first occur? _____

Duration: Frequency of symptoms? _____

Characterized as/Severity: Describe the symptoms/pain. How bad are they? _____

_____

Associated Signs and Symptoms: Are there any other symptoms associated with your problem?_____

_____

Modifying Factors: What makes the condition better and/or worse? _____

_____

BIRTH HISTORY: *Please describe the patient's:*

Gestational age: __Pre-term (how many weeks) _____ __Full Term __Post-term

Pregnancy complications: __None __Other: _____

Delivery mode: __Vaginal delivery __C-Section

Delivery complications: __None __Other: _____

Birth weight: _____

Hospital stay: __Routine newborn care (Home on: __Day 2 __Day 4 __Other ____)____Neonatal ICU (How long ____)

__Other: _____

PAST MEDICAL HISTORY: *Has the patient ever been diagnosed with any of the following (currently or in the past):*

__ADD	__Anemia	__Cancer	__Down Syndrome	__High Cholesterol
__ADHD	__Anxiety	__Diabetes	__Genetic Problem	__Seizures
__Allergies	__Asthma	__Depression	__High Blood Pressure	__Thyroid Problem

__Other: _____

_____

_____

_____

ALLERGY HISTORY:

__None **__ NKDA (No Known Drug Allergies)**

__Acetaminophen (Tylenol) __Aspirin __Iodinated Contrast Media __Penicillin __Sulfa Drugs

__Other: _____

_____

PAST SURGICAL HISTORY:

List significant surgeries or injuries (Write "None" if you have no past surgeries or injuries):

Surgeries/Injuries *Date(s) or Age/Surgeon*

_____

_____

_____

_____

MEDICATION HISTORY: *List any prescription or over the counter medications, vitamins, minerals, and herbals that you (the patient) are currently taking:* **__Not currently taking any medications**

Name of Medication	**Dosage**	**Name of Medication**	**Dosage**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HISTORY:

Has a member of the patient's family (parents, siblings, grandparents, aunts, uncles, cousins) been diagnosed with any of the following conditions (include deceased family members)? *Place an "X" under the family member with the condition, and indicate if the family member passed away due to that condition. If no family members have it, check "None".*

	Mother	**Father**	**Sibling(s)**	**Grandparent(s)**	**Other**
Aneurysms	_____	_____	_____	_____	_____
Arrhythmia	_____	_____	_____	_____	_____
Cardiomyopathy	_____	_____	_____	_____	_____
Congenital Heart Defect	_____	_____	_____	_____	_____
Deafness at birth	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Enlarged Heart	_____	_____	_____	_____	_____
Heart Attack < age 50	_____	_____	_____	_____	_____
Heart Disease as adult	_____	_____	_____	_____	_____
Heart Surgery	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____
High Cholesterol	_____	_____	_____	_____	_____
Irregular Heart Beats	_____	_____	_____	_____	_____
Lupus	_____	_____	_____	_____	_____
Marfans	_____	_____	_____	_____	_____
Mitral Valve Prolapse	_____	_____	_____	_____	_____
Pacemaker	_____	_____	_____	_____	_____
Prolonged QT Syndrome	_____	_____	_____	_____	_____
Stillbirths	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____
SIDS	_____	_____	_____	_____	_____
Sudden/Accidental Death	_____	_____	_____	_____	_____
Syncope/Passing out	_____	_____	_____	_____	_____
Tachycardia	_____	_____	_____	_____	_____
Valve Leak/Narrowing	_____	_____	_____	_____	_____

__Other: _____

_____

_____

SOCIAL HISTORY:

Please describe the patient's family members ___Mother ___Father ___Brother(s) ___Sister(s)
Others who reside in the home (list): _____

Please describe your (the patient's) *current* School Status?__Regular school __Special education __Full-time __Part-time

Please describe your (the patient's) *current* Tobacco Use?
__Current every day smoker __Current some day smoker __Former Smoker __Never Smoked __Unknown
Tobacco/Smoke 2nd hand Exposure Details: __None __Minimal __Frequent __Daily

Have you (the patient) ever used any illicit drugs? __Yes __No
If yes, please indicate what type of drug and how often: _____

Do you (the patient) drink alcoholic beverages? __Yes __No
If yes, please indicate what type of beverage and how many servings per day: _____

Do you (the patient) drink caffeinated beverages? __Yes __No
If yes, please indicate what type of beverage and how many servings per day: _____

Please describe your (the patient's) current exercise routine: __Inactive __Light __Moderate __Heavy __Vigorous

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REVIEW OF SYSTEMS:

Has the patient recently experienced any of the following symptoms? *Please mark either Yes or No for each of the items below.* If you don't understand something place a question mark "?" by it. Your doctor will discuss any positive responses with you.

General:	Yes	No
• Easy Fatigue	___	___
• Frequent Infections	___	___
• Paleness	___	___
• Poor Weight Gain	___	___
• Recent Weight Loss	___	___
• Recent Weight Gain	___	___

Skin:	Yes	No
•Abnormal Color: Blue or Very Pale	___	___
•Eczema	___	___
•Hemangiomas/Birthmarks	___	___
•Prominent Veins	___	___
•Rash	___	___

HEENT:	Yes	No
•Blurry Vision	___	___
•Cracked/Sore/Red Lips	___	___
•Ear Pain	___	___
•Glasses/Contact Lenses	___	___
•Hearing Loss	___	___
•Loss or Change of Vision	___	___
•Nasal Congestion	___	___
•Nosebleed	___	___
•Pink/Red Eyes	___	___
•Seasonal/Chronic Runny Nose	___	___
•Sore Throat	___	___
•Watery Eyes	___	___

Neck:	Yes	No
•Neck Pain	___	___
•Neck Stiffness	___	___
•Neck Swelling	___	___

Respiratory:	Yes	No
•Asthma	___	___
•Chest Pain	___	___
•Difficulty Breathing	___	___
•Frequent Coughing	___	___
•Lung Collapse	___	___
•Noisy Breathing	___	___
•Pneumonia	___	___
•Shortness of Breath	___	___
•Wheezing	___	___

(Review of Systems continued)

Cardiovascular: Yes No
- Blueness ..... __..__
- Chest Pain ..... __..__
- Dizziness..... __..__
- Easy Fatigue ..... __..__
- Heart Murmur..... __..__
- High Blood Pressure..... __..__
- High Cholesterol..... __..__
- Irregular Heart Beat ..... __..__
- Low Blood Pressure..... __..__
- Palpitations or Rapid Heart Beat..... __..__
- Passing Out ..... __..__
- Poor Exercise Tolerance..... __..__

Gastrointestinal: Yes No
- Coughing/ Choking when Eating .....__ .__
- Difficulty Feeding.....__ .__
- Frequent Diarrhea .....__ .__
- Frequent Vomiting .....__ .__
- Heartburn/Stomach Aches ...__ .__
- Poor Eater .....__ .__

Genitourinary: Yes No
- Blood in Urine.....__ .. __
- Decreased Urine .....__ .. __
- History of Urinary Tract Infections .....__ .. __
- Painful Urination.....__ .. __

Musculoskeletal: Yes No
- Chest Cavity Abnormality..__ .. __
- Joint or Muscle Pain .....__ .. __
- Joint or Muscle Swelling....__ .. __
- Loose/Flexible Joints .....__ .. __
- Redness/ Inflammation of Joints.....__ .. __
- Scoliosis .....__ .. __

Neurological: Yes No
- Abnormal Movements .....__ .. __
- Diagnosis of AHD/ADD .....__ .. __
- Difficulty Speaking.....__ .. __
- Headaches .....__ .. __
- Numbness.....__ .. __
- Seizures .....__ .. __
- Weakness .....__ .. __

Psychiatric: Yes No
- Depression .....__ .. __
- Mood Swings.....__ .. __
- Nervousness.....__ .. __
- Temper Outburst .....__ .. __

Endocrine/Glands: Yes No
- Excessive Sweating .....__..__
- Excessive Thirst/Hunger ..__..__
- Heat Intolerance.....__..__
- Cold Intolerance .....__..__

Hematology: Yes No
- Anemia..... __..__
- Easy Bruising/Bleeding .. __..__
- Swollen/Enlarged Lymph Nodes..... __..__

Form Filled Out By:

☐Patient, ☐Mother, ☐Father, ☐Relative: _____, ☐Staff: _____

☐Translator: _____

Physician Review: _____ **Date:** _____

☐AMV ☐SGL ☐DML ☐JIH