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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
- high blood pressure
- asthma
- arthritis
- thyroid problems
- diabetes (adult or juvenile onset)
- alcohol/drug abuse
- neurologic disorders (multiple sclerosis, Parkinson's)
- irritable bowel
- high cholesterol
- osteoporosis/-penia
- eye disease
- kidney stones
- cancer (type, tx) _____
- pinched nerve/sciatica
- depression/anxiety
- kidney failure
- stomach ulcers
- bleeding problems
- heart murmur
- lupus
- colon polyps
- hepatitis (A, B, or C)
- stroke (age/cause) _____
- migraine headaches
- eating disorder
- interstitial cystitis
- anemia (cause) _____
- blood clots (age, cause) _____
- blood transfusion (year) _____
- peripheral vascular occlusive disease (PVOD--poor arterial circulation)
- heart disease (include heart attacks, angiograms, stents, arrhythmia)
- seizure disorder
- enlarged prostate
- 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
 - constipation
 - diarrhea
 - loss of appetite
 - shortness of breath
 - low sex drive
 - low back pain
 - neck pain
 - dizziness
 - dry eyes
 - swollen glands
 - dry skin
 - lumpy breasts
 - other(s)--please explain _____
- palpitations
 - heartburn
 - nausea
 - night sweats
 - persistent fatigue
 - blood in stools
 - painful urination
 - headaches/migraines
 - memory loss
 - restless legs
 - varicose veins
 - hair loss
 - nipple discharge
- chest pain
 - abdominal pain
 - vomiting
 - hemorrhoids
 - insomnia/poor sleep
 - blood in urine
 - urinary incontinence
 - skin/nail problems
 - hearing loss
 - anxiety/depression
 - hot flashes
 - pain with sex
 - acne
- allergies (itchy, sneezy, runny, and/or stuffy)
 - difficulty with swallowing
 - unexpected significant weight gain/loss
 - need to urinate during sleep _____ # times/night
 - poor exercise tolerance
 - frequent urinary tract infections
 - difficulty with erections
 - cold hands and/or feet
 - vaginal itching/discharge
 - recurrent yeast infections
 - bleeding between menstrual cycles
 - bleeding with sex
 - pelvic pain (not necessarily with sex)

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 _____