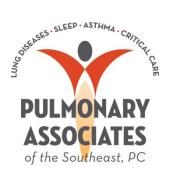
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PATIENT INTAKE FORM

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

Name								
	hat referred you:							
Briefly describe your symptor	ns:							
Past Medical History:								
COPD	Acid Reflux		Hypertension	Thyroid Disorder				
Nodule/Mass	Diabetes		Heart Failure	High Cholesterol				
Asthma	Other:							
Past Surgery History:								
Appendectomy	Hysterectomy		Gallbladder	Hernia				
Heart Bypass	Tonsils		Hip	Back				
Prostate	Other:							
List the names of all medic Medicine Name	Dosage	Frequency	Medicine Name	Dosage Frequency				
Allergies: None	Other:							
Family History: Please chec	ck if your Mother,	Father, Brothe	r, Sister ever had any of the fo	llowing				
Lung Cancer	Heart	Heart Disease High Blood Pressure Diabetes						
Prostate Cancer	Other:							

PATIENT INTAKE FORM

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

Current / Everyday		Former	Years	
Currer	nt / Some Days	Never	Packs	
Currer	nt / Everyday	Former	Amount	
Currer	nt / Some Days	Never		
Single	☐ Married	☐ Divorced	☐ Widowed	
าร:				
fatigue?		Yes	No	
ecent weight _	gainloss? I	f so, how much?		
headaches? If	so, describe:		Yes	No
an earache?			Yes	No
aring loss?		Yes	No	
not connected		Yes	No	
n or postnasal		Yes	No	
told you:	reathing during sleep?	Yes	No	
tting to sleep?		Yes	No	
the morning?		Yes	No	
time sleepines	Yes	No		
reath? If so, (c	Yes	No		
e?			Yes	No
•			Yes	No
oughing up ar	ything?		Yes	No
	Currer Currer Currer Currer Currer Single Single Single an earache? aring loss? anot connected on or postnasal told you: tting to sleep? the morning? time sleepines reath? If so, (of ee?)	Current / Some Days Current / Everyday Current / Some Days Single	Current / EverydayFormerNeverNeverNeverNever	Current / Some DaysNever

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PATIENT INTAKE FORM

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

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)Re	estActiv	rityBoth
18. Is the chest pain associated with (check):NauseaSweatingSho	ortness of breat	h
19. Does the chest pain radiate:across chestdown armup 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:		

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