Summit Health

PATIENT INTAKE INFORMATION

Today's Date: ____/____/____

Name: _____ Age: _____ Date of Birth: ____/____/____

Why are you seeing the doctor today? _____

Check: ☐ Right ☐ Left

When did the injury happen? _____

How did the injury happen? _____

Accident? ☐ No ☐ Yes Type: ☐ Auto ☐ Work ☐ Other: _____

Referring Physician: _____ ☐ Check if none

Primary Physician: _____ ☐ Check if none

Have you had X-rays taken (for this problem)? ☐ No ☐ Yes When/where: _____

Have you had an MRI (for this problem)? ☐ No ☐ Yes When/where: _____

Medical History:

☐ Cancer	☐ Hypertension/Heart Disease	☐ Ulcers
☐ Anxiety/Depression	☐ Stroke/Vascular Disease/Blood Clot	☐ Diabetes
☐ Acute Infections	☐ Asthma/Other Breathing Problems	☐ Arthritis/Gout
☐ Bleeding Tendency	☐ Convulsions/Seizures	☐ None Apply

Current medications (including over-the-counter), including dosage and frequency: _____

_____

_____ ☐ Check if none

Allergies (medications, environmental, latex): _____

_____ ☐ Check if none

Past surgical history? ☐ No ☐ Yes If yes, please list surgery & dates of surgery: _____

_____

Family history (list any conditions that run in your family and which family member): _____

_____

_____

Pharmacy name & address (for temporary medications): _____

_____ Phone: (____) ____ - ____ Fax: (____) ____ - ____

PLEASE TURN AND COMPLETE PAGE 2!

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PATIENT INTAKE INFORMATION

Name: _____

Social History:

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Occupation: _____

Do you consume alcoholic beverages? ☐ No ☐ Yes _____(quantity) ☐ Daily ☐ Weekly ☐ Monthly

Smoking currently? ☐ No ☐ Yes _____ packs for _____ years.

Previously smoked _____ packs per day for _____ years. Quit _____ years ago.

Review of Systems:

Are you currently having or have you had problems with: *(Describe yes responses)*

History of fractures	☐ No	☐ Yes	_____
Eyes, blurring of vision, recent change in eyesight	☐ No	☐ Yes	_____
Ears, nose, or throat problems	☐ No	☐ Yes	_____
Skin rashes or related skin conditions	☐ No	☐ Yes	_____
Persistent fever, chills, or night sweats	☐ No	☐ Yes	_____
Digestive or bowel problems	☐ No	☐ Yes	_____
Frequent urination, or painful or bloody urination	☐ No	☐ Yes	_____
Recent gain or loss of more than 10 pounds	☐ No	☐ Yes	_____

Vital Signs: (Office Use Only)

Height: _____ Weight: _____ Temperature: _____

Patient's Signature: _____ Date: ____/____/____

Physician's Signature: _____ Date: ____/____/____