Camellia Place
HEALTHCARE SERVICES

NEW PATIENT INTAKE

Name: _____ Date of Visit: _____

Date of Birth: _____ Age: _____ Race/ Ethnicity_____

Address: _____

_____

Who lives with you or is involved in your care? _____

_____

Phone Home/ Cell: _____ Email: _____

Sign here to authorize: _____

Reason for visit: ☐ Establish New Care ☐Other Health Concerns, please explain: _____

_____

FOR FEMALE PATIENTS ONLY

Reproductive History:

Age at 1st period: ____Yrs

Age at menopause: ____Yrs
Pregnancies: ____Yrs
Live births: ____Yrs
Age at 1st pregnancy: ____Yrs

Last menstrual period: _____
Last pap smear: _____Yrs

Have you ever or are you currently using hormone replacement therapy: ☐Yes ☐No
If yes, for how long? _____
When stopped? _____

Past Medical Problems: ***(check boxes that apply, describe below)***

☐High Blood Pressure ☐Diabetes ☐Heart Disease/Heart Attack ☐Rheumatic Fever ☐Kidney Disease ☐Lung Disease/COPD
☐Asthma ☐Seizures/Epilepsy ☐Stroke ☐Cancer ☐Hepatitis ☐Tuberculosis ☐Emotional/Psychiatric Problems ☐Other (list)

_____

_____

List all Previous Surgical Operations/Procedures (for example, colonoscopy, cardiac stent, etc.). and the date if known:
☐NONE

_____

_____

Preferred Pharmacy: _____ Location: _____ Phone number: _____

Medications: with dosages and times of day taken ***(Attach list if needed)***

_____

_____

Are you allergic to any medications or food? ☐Yes ☐No ***(If yes, please list)*** **ALLERGIC TO LATEX?** ☐Yes ☐No

_____

Do you have an Advanced Directive / Living Will: ☐ Yes ☐ No **Do you have a Health Care Proxy?:** ☐ Yes ☐ No

If <u>No</u> would you like information on an Advanced Directive? ☐Yes ☐No **(If Yes, please bring copy to office visit.)**

<u>Social History</u>

Occupation: _____ Retired: _____ Disabled: _____

Living Arrangements? Alone_____ Spouse/Family_____ Other _____

☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Do you exercise? ☐Yes ☐No Explain: _____ Do you use alcohol: ☐Yes ☐No If yes, for how much and how often? _____

Do you use tobacco now: ☐Yes ☐No Prior tobacco use? ☐Yes ☐No Describe Tobacco use (for example, packs per day):_____

Do you have any physical safety concerns that we can help you address today? ☐Yes ☐No Explain:

_____

<u>Family History</u>: Does/did anyone in your family (blood-related) have cancer? If so, list their relation to you, what cancer they had, and how old they were when they were diagnosed. **Any other family illnesses?**

_____

_____

_____

Review of Symptoms: ***<u>Please check YES</u>*** - ONLY to ***<u>symptoms you are experiencing</u>*** TODAY

<u>General</u>	**<u>Yes</u>**
Weakness/Fatigue	____
Weight loss	____
Fever/chills	____
Night sweats	____
Pain	____
<u>Eyes</u>	**<u>Yes</u>**
Vision changes	____
Double vision	____
Cataracts	____
Glaucoma	____
<u>Head/Neck</u>	**<u>Yes</u>**
Headache	____
Blackout spells	____
Changes in hearing	____
Changes in taste/smell	____
Thyroid Problems	____
Neck lumps	____
Ear pain	____
<u>Disabilities</u>	**<u>YES</u>**
Assisted Living	____

<u>Musculoskeletal</u>	**<u>Yes</u>**
New aches/pains	____
Arthritis	____
Osteoporosis	____
<u>Heart</u>	**<u>Yes</u>**
Chest Pain	____
Heart Attack	____
Irregular heart beat	____
Heart Failure	____
Swelling in ankles	____
Palpitations	____
<u>Gastrointestinal</u>	**<u>Yes</u>**
Abdominal pain	____
Nausea/vomiting	____
Vomit blood	____
Difficulty swallowing	____
Heartburn/indigestion	____
Blood in stool	____
Black/tarry stool	____
Change in stool size	____
Constipation	____
Yellow Jaundice	____

<u>Hematologic</u>	**<u>Yes</u>**
Anemia	____
Easy bruising	____
Clotting problem	____
<u>Kidney</u>	**<u>Yes</u>**
Blood in urine	____
Kidney/bladder infxn	____
Kidney stones	____
Painful urination	____
Difficulty urinating	____
<u>Skin</u>	**<u>Yes</u>**
Rash	____
Skin cancer	____
Change in mole	____
<u>Neurologic</u>	**<u>YES</u>**
Tingling	____
Numbness	____
Weakness	____
<u>Psychiatric</u>	
Depression	____
Anxiety	____
Mood swings	____
Suicidal Thoughts	____

Explain Disabilities:_____

<u>MD/ NP Signature that form was reviewed</u>: _____Date: _____

HPI or Additional Notes:

Location
Quality
Severity
Duration
Timing
Context
Modifying Factors
Associated S&S