

SMO PATIENT INTAKE HISTORY FORM

DATE: _____

First Name:		MI:	Last:	
DOB:		SSN:		Occupation:
Primary Care Provider:			Referring Provider:	
CHIEF COMPLAINT				
Why are you seeing the doctor today?				
MEDICAL HISTORY				
Major medical problems:				
Surgery:				
Date:		Reason:		
Date:		Reason:		
Date:		Reason:		
Date:		Reason:		
Complication from surgery? yes no If yes, please describe:				
MEDICATION ALLERGIES:				
OTHER ALLERGIES:				
NO KNOWN DRUG ALLERGIES				
Current Medications (include prescription, over-the-counter, herbal and vitamin supplements):				
FAMILY HISTORY				
Father disease(s):		_____	If deceased, at what age?	
Mother disease(s):		_____	If deceased, at what age?	
SOCIAL HISTORY				
Habits:				
Smoke:	Number of years:		Packs per day:	If quit, how long ago?
Drink:	never	some	Average per day:	OR per month:
Exercise:				
Type:			Times per week:	
Type:			Times per week:	
Type:			Times per week:	

REVIEW OF SYSTEMS

PLEASE BRIEFLY COMMENT ON ANY YES ANSWER		YES	NO	COMMENT
GENERAL	Change in weight or energy level	<input type="checkbox"/>	<input type="checkbox"/>	
BONES	Broken bones in past	<input type="checkbox"/>	<input type="checkbox"/>	
	Bone or joint pain	<input type="checkbox"/>	<input type="checkbox"/>	
	Swelling or deformity	<input type="checkbox"/>	<input type="checkbox"/>	
RESPIRATORY	Asthma or pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	
	Cough or shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	
	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	
SKIN	Change in wart or mole	<input type="checkbox"/>	<input type="checkbox"/>	
	Rash	<input type="checkbox"/>	<input type="checkbox"/>	
	Lumps	<input type="checkbox"/>	<input type="checkbox"/>	
HEENT	Glasses or contacts	<input type="checkbox"/>	<input type="checkbox"/>	
	Problems swallowing or hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	
	Headaches or sinus congestion	<input type="checkbox"/>	<input type="checkbox"/>	
NECK	Swollen glands	<input type="checkbox"/>	<input type="checkbox"/>	
	Pain or stiffness	<input type="checkbox"/>	<input type="checkbox"/>	
GI/GU	HEPATITIS A, B or C	<input type="checkbox"/>	<input type="checkbox"/>	
	Stomach problems	<input type="checkbox"/>	<input type="checkbox"/>	
	Bowel Problem, black or bloody stools	<input type="checkbox"/>	<input type="checkbox"/>	
	Urinary problems or blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	
	Prostate problems	<input type="checkbox"/>	<input type="checkbox"/>	
	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	
MOOD	Depression or anxiety	<input type="checkbox"/>	<input type="checkbox"/>	
	Sleep disorder	<input type="checkbox"/>	<input type="checkbox"/>	
HEART	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	
	Chest pain or racing heart	<input type="checkbox"/>	<input type="checkbox"/>	
	Swollen feet, varicose veins or blood clots	<input type="checkbox"/>	<input type="checkbox"/>	
NEUROLOGICAL	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
	Balance problems	<input type="checkbox"/>	<input type="checkbox"/>	

Any other health problems or concerns that your doctor should know about.
