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New Patient Intake Form

Confidential Contact Information:

Full Legal Name: _____/ _____ Preferred Name:_____
Last name *First name*

Address: _____/ _____/ _____/ _____
Street #/ PO Box *City* *State* *Zip code*

Telephone: (H)_____ (W)_____(C)_____

Email Address: _____

Would you like to be added to our list to receive occasional newsletters? Sure No thanks

What is the best way to communicate with you? (circle one) Email / Home ph / Work ph / Cell ph

Is there any place you do NOT want us to leave a message? _____

Emergency Contact: _____/_____
Name *Relationship*

Emergency Contact Phone Number: _____

How did you hear about Dr. Schulz? _____

Demographics & Social History:

Age: _____ Date of Birth:_____ Sex: M / F Gender: M / F

Relationship: ____Single ____Married ____Partnership ____Seperated ____Divoriced ____Widowed

Occupation: _____ Hours per week: _____

Employer: _____ SSN: ____-____-_____

Do you have a primary care provider (PCP)? Y N

Name: _____Location:_____

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Social History:
Do you currently or have you ever smoked cigarettes or used any tobacco products ? Yes No

Current or Past: _____When did you quit? _____

If currently using tobacco products how often and how much? _____

Do you currently drink alcohol? Yes No If so, how many drinks per week? _____

Have you ever felt you needed to cut down on your drinking? Yes No

Have you ever felt guilty about drinking? Yes No

Health Concerns:
List in order of importance, your health concerns and how long you have had these concerns or condition(s).

1. _____ ____
2. _____ ____
3. _____ _____
4. _____ _____

Have you ever been treated for the above conditions? How and what were the results?
_____
_____

Date of last physical exam: _____ Any abnormal findings: Yes No If yes, please explain:
_____
_____

General:
Height: _____ Weight: _____lbs. Weight one year ago: _____lbs.
When during the day is your energy the best? _____Worst?_____

Medications:
List all prescription & over the counter medications you are currently taking: (not supplements)

Med: _____ Dose: _____ How long?_____

Med: _____ Dose: _____ How long?_____

Med: _____ Dose: _____ How long?_____

Med: _____ Dose: _____ How long?_____

Pharmacy you prefer: _____ Location: _____

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Supplements:
List all the herbs, vitamins, and minerals you are currently taking:

Supplement: _____ Dose: _____ How long?_____

Supplement: _____ Dose: _____ How long?_____

Supplement: _____ Dose: _____ How long?_____

Supplement: _____ Dose: _____ How long?_____

Allergies:

Are you allergic to any medications? Yes No

If yes, please list: _____

What is your reaction to this medication(s)? _____

Do you have any known allergies to foods or environmental exposures (e.g. cats, mold, dust)? Y N

Please list: _____

What is your reaction? _____

Personal Medical History:
What hospitalizations or surgeries have you had? Please give dates if possible.

_____

_____

_____

Family History:
In order to create a preventative wellness plan, it is important to know what diseases run in your family (i.e heart disease, cancer, diabetes, autoimmune conditions, obesity, drug addiction, mental illness)

Mother: _____ Alive Deceased

Father: _____ Alive Deceased

Siblings: _____ Alive Deceased

Paternal GP: _____ Alive Deceased

Maternal GP: _____ Alive Deceased

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Review of systems:

Please circle any symptoms you are currently having, or have recently experienced.

Head/ Eyes/ Ears

Headaches	Migraines	Head Injury	Ringing in ears
Earaches	Dizziness	Cataracts	Glaucoma

Nose/ Sinuses

Stuffiness	Allergies	Loss of smell	
Sinus infections	Frequent colds	Nose bleeds	

Mouth/ Throat

Hoarseness	Frequent sore throat	Gum problems	

Neck

Lumps	Swollen glands	Pain or stiffness	

Skin

Rashes	Psoriasis	Eczema	Acne
Rosacea	Discoloration	Moles of concern	Hives

Respiratory

Asthma	Shortness of breath	Cough	

Cardiovascular

Chest pain	Murmur	Blood clots	Ankle swelling
High blood pressure			

Gastrointestinal

Diarrhea	Constipation	Change in frequency	Ulcers
Heartburn	Hemorrhoids	Bloating	Pain

Urinary

Incontinence	Freq. infections	Painful urination	Kidney stones
Freq. at night			

Blood/ Peripheral vascular

Anemia	Easy bruising	Varicose veins	Blood clots

Musculoskeletal

Joint pain	Muscle spasms	Back pain	Sciatica
Arthritis	History of whiplash		

Neurological

Numbness /tingling	Loss of memory	Seizures

Mental/ Emotional

Mood swings	Anxiety	Depression

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Male Reproductive

Testicular mass	Discharge/ Sores	Erectile dysfunction	Hernias
Prostate issues	Testicular pain	Low libido	

Female Reproductive

Age of 1st menses:_____yo. Age of last menses (if post-menopause) _____yo.

How many days between periods? _____ How many days do you bleed?_____

Date of last PAP smear? _____ Was is it normal? Yes No

Current use of birth control? Y N If yes, what type?_____

Painful menses	Endometriosis	Ovarian cysts	Heavy flow
Fertility issues	Menopause symptoms	Breast lumps	Low libido
Pain with intercourse	Breast tenderness	Cycles regular	PMS
Sexually active	Discharge/ Sores		

Number of pregnancies: _____ Live births:_____ Miscarriages:_____ Abortions:_____

Ages of children? _____ Complications of pregnancy?_____

Anything else medically necessary that was not asked, or extra space if needed:

_____

_____

_____

_____

_____

Your health care goals:

_____

_____

_____

_____

Your level of commitment to achieve these goals (0-10) with 10 being 100% commitment

_____/ 10

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