New Patient Intake Form

Name: _____ Date: _____

Height: _____ Weight _____ Blood Pressure: _____

Physician: _____

Main reason for today's visit: _____

Review of Symptoms: Please circle any

Unexplained weight loss / gain	Blood or change in bowel movement	Headache
Unexplained fatigue / weakness	Constipation	Memory loss
Asthma	Urinary leakage	Fainting
HTN	Blood in urine	Dizziness
Increased cholesterol	Nighttime urination	Numbness / tingling
Diabetes	Increased urinary frequency	Unsteady gait
Thyroid disorder	Abnormal Discharge: penis or vagina	Frequent falls
Vision Aids needed	Concern with sexual function	Anxiety / stress / irritability
Hearing Aids needed	Neck pain	Sleep problem
Heartburn /GERD	Back pain	Lack of concentration
OA/RA	Muscle / joint pain	History of Abuse
Osteoporosis	Cardiac arrhythmias	Eating disorder

Past Medical History: _____

_____

_____

Past surgical History: _____

_____

_____

Medications : _____

_____

_____