



HEALTH INTAKE FORM

Patient Name _____ Referring MD _____

Today's Date _____ MRN _____ DOB _____ Sex M F

Chief Complaint (reason for your visit today) _____

Previous Medical History:

Medical Problem	Date of Onset

Previous Surgeries/Hospitalizations/Procedures: (include Colonoscopy, Sigmoidoscopy, Endoscopy, etc):

Surgery/Procedure/Hospitalization	Type	Date(s)

Please indicate if you, or any of your blood relatives have had any of the following:

- Colon or GI Cancer Personal Family
- Type: _____
- Colonic Polyps Personal Family
- Peptic Ulcers Personal Family
- Inflammatory Bowel Disease Personal Family
- Liver Disease Personal Family

Social History:

- Tobacco Use No Yes Frequency _____
- Alcohol Use No Yes Frequency _____ -
- Drug Use No Yes Frequency _____
- Married Single Divorced Widowed

Allergies to Medications/Non-Medications and/or Foods: Y N If yes, please list type and reaction:

Medication/Non-Med/Food	Reaction

Current Medication and Dosages: Please list all medications you are currently taking including over-the-counter, vitamins and herbal remedies:

Medication Name	Dosage (mg/mcg)	Frequency	Total Dose



Family History: Indicate the following blood relatives current age, any diseases they may have, or if deceased, cause of death:

Relation	Alive (age)	Deceased (age)	Cause of Death	Health Problems
Mother				
Father				
Siblings				
Grandparentsr(s)				

Review of Systems: Are you currently having, or have you had problems with your (check boxes that are positive and explain)

Constitutional No Yes Fatigue Fever Weight loss Headache Other _____

Eyes No Yes Blurred Vision Glasses Other _____

Ears, Nose, Throat No Yes Congestion Hearing Loss Jaw discomfort Other _____

Heart No Yes Fainting ChestPain Edema Irregular Heartbeat Murmur Palpitations
Dizziness Explain _____

Lungs, Breathing No Yes Shortness of Breath Wheezing Cough Other _____

Bladder No Yes Incontinence Urinary Tract Infections Difficulty Urinating Other _____

Endocrine No Yes Diabetes Thyroid Problems Delays in growth Other _____

Muskoskeletal No Yes Joint pain Leg pain Hx of broken bones Other _____

Bleeding Problems No Yes Anemia Prolonged bleeding after cut Other _____

Neurological No Yes Numbness/Tingling Dizziness Headaches Frequent Falls Other _____

Integumentary No Yes Rashes Skin disorders Connective tissue disorders Other _____

Psychiatric No Yes Change in mood or behavior Change in sleep pattern Other _____

Immunologic/Allergic No Yes Asthma Communicable Diseases Chronic rashes Hay Fever Other _____

GI Review of Systems: Are you currently having, or have you had problems with

Abdominal Pain No Yes Frequency _____ Explain _____

Rectal Bleeding No Yes Frequency _____ Explain _____

Black stools No Yes Frequency _____ Explain _____

Constipation No Yes Frequency _____ Explain _____

Diarrhea No Yes Frequency _____ Explain _____

Weight change No Yes Frequency _____ Explain _____

Heartburn No Yes Frequency _____ Explain _____

Nausea/Vomiting No Yes Frequency _____ Explain _____

Incontinence No Yes Frequency _____ Explain _____

Blood Transfusions No Yes Frequency _____ Explain _____

Patient Signature: _____ **Date** _____

Reviewed by _____ **Date** _____

David D. Markowitz, MD