Littleton Internal Medicine Associates

NEW PATIENT INTAKE AND HISTORY FORM
(Please print)

Date: _____
Name: _____ Date of Birth: _____

Local Pharmacy: _____
(Name/City/Phone #)
Mail Order Pharmacy: _____
(Name/City/Phone #)

PROBLEM LIST/PAST MEDICAL HISTORY:

Have you been diagnosed with any of the following (currently or in the past)?

___ Abnormal Heart Rhythm
___ Alcoholism/Substance Abuse
___ Alzheimer's
___ Anemia
___ Angina (chest pain)
___ Anxiety
___Arthritis
___ Asthma
___ Bipolar Disorder
___ Bleeding Disorder
___ Blood Clots
___ Cancer
___Cataract
___ Chronic Kidney Disease
___ Colon Polyps
___ Congestive Heart Disease
___ Congestive Heart Failure
___ COPD
___ Coronary Artery Disease
___ Crohn's Disease
___CVA/Stroke
___ Depression
___ Diabetes – Type 1
___ Diabetes – Type 2
___ Diverticulitis
___ Emphysema
___ Fibromyalgia
___ Gallstones
___ Gastric Reflux
___ Genital Herpes Simplex
___ GERD, Reflux
___ Gallstones
___ Glaucoma
___ Gout
___ Heart Murmur
___ Hearty Valve Disease
___ Headache/ Migraine
___ Hepatitis
___ High Blood Pressure
___ High Cholesterol
___ HIV/AIDS
___ IBS
___ Kidney Disease
___ Kidney Stones
___ Liver Disease/ Hepatitis
___ Lupus
___ Menopause/Age
___ Memory Loss
___ Obesity
___ Osteoarthritis
___ Osteoporosis
___ Pancreatitis
___ Parkinson
___ Pneumonia
___ Rheumatoid Arthritis
___ Rheumatic Fever
___ Seasonal Allergies
___ Seizures
___ Shingles
___ Sleep Apnea
___ Stomach Ulcers
___ Thyroid
___TIA (mini stroke)
___ Tuberculosis

Other_____
_____
_____
_____
Comments_____
_____
_____
_____
_____
_____
_____

ALLERGY HISTORY: Please include all allergies such as medication and/or medical supplies (i.e: latex, iodine or tape

☐ **None** ☐ **NKDA (No Known Drug Allergies)**

_____Acetaminophen/reaction_____ _____ Aspirin/reaction_____

_____Epinephrine/ reaction_____ _____ Erythromycin/ reaction_____

_____ Latex/ reaction_____ _____ Lidocaine/reaction_____

_____Lidocaine/reaction_____ _____ Penicillin/reaction_____

_____Sulfa Drugs/ reaction_____

Name of other medications **Reactions:**

_____ _____

_____ _____

MEDICATION HISTORY:

☐ I am not currently taking any medications

List any medications, vitamins, minerals, and herbals that you are currently taking:

Name of Medication	**Dosage**	**How Often**

FAMILY HISTORY:

Has any member of your family been diagnosed with any of the following conditions (include deceased family members)? Place an "X" under the correct family member with the condition and indicate if the family member passed away due to that condition.

	Mother	**Father**	**Sister**	**Brother**	**Mother's Parents**	**Father's Parents**
Arthritis						
Asthma						
Cancer						
Cataract						
COPD						
Depression						
Diabetes						
Heart Disease						
High Blood Pressure						
High Cholesterol						
Kidney Disease						
Obesity						
Osteoporosis						
Seizures						
Thyroid Problems						
Tuberculosis (TB)						

PAST SURGICAL HISTORY:

☐ **None**

___ Angioplasty (stent)	___ Cataract Surgery, Right	___ Hip Replacement, Right	___ Sinus Surgery
___ Appendectomy	___ Cholecystectomy	___ Knee Replacement, Left	___ Thyroidectomy, Left
___ Back Surgery	___ Coronary Art. Bypass	___ Knee Replacement, Right	___ Thyroidectomy, Right
___ Breast Surgery, Left	___ Hemorrhoidectomy	___ Neck Surgery	___ Tonsillectomy
___ Breast Surgery, Right	___ Hernia Repair	___ Shoulder Replacement, Left	
___ Cataract Surgery, Left	___ Hip Replacement, Left	___ Shoulder Replacement, Right	

Other: _____

Females Only:

___ Cesarean Delivery	___ Ovary Removal, Left
___ Total Hysterectomy (uterus and cervix removed)	___ Ovary Removal, Right
___ Partial Hysterectomy (uterus only removed)	___ Tubal Ligation

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SOCIAL HISTORY:

Marital Status: ☐ Single ☐Married ☐Separated ☐Divorced ☐Widowed

Children ___Yes ___No **Sons**_____ **Daughters**_____

Occupation:_____

Please describe your current tobacco use:

☐Smoker, current status unknown ☐Light tobacco smoker ☐Heavy tobacco smoker ☐Current every day smoker ☐Current some day smoker ☐Former smoker ☐Never smoker ☐Unknown if ever smoked

If you currently use tobacco or have in the past, please indicate what type (cigarettes, cigars, pipe, chew) and how many years: _____

Do you drink alcoholic beverages? ☐Yes ☐No

If yes, please indicate how many drinks: _____ per day / week / month (circle one)

Have you ever used any illicit drugs? ☐Yes ☐No

If yes, please indicate what type of drug and how often: _____

Please describe your sexual preference: ☐Bisexual ☐Heterosexual ☐Homosexual ☐Unknown

Are you sexually active? ☐Yes ☐No **My partner is:** ☐Male ☐Female

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REVIEW OF SYSTEMS:

Please place a check mark in the box next to any of the following symptoms or problems if you have experienced them recently or have concerns about them. If you don't understand something place a question mark "?" by it. Your doctor will discuss any positive responses with you.

General: ☐**Normal**
- ❑ Appetite Loss
- ❑ Fatigue
- ❑ Fever
- ❑ Night Sweats
- ❑ Weight Change

Skin: ☐**Normal**
- ❑ Acne
- ❑ Bruising
- ❑ Dryness
- ❑ Excessive Sweating
- ❑ Hair Loss
- ❑ Itching
- ❑ New Lesions
- ❑ Rash

HEENT: ☐**Normal**
- ❑ Blurred Vision
- ❑ Eye Redness
- ❑ Headache
- ❑ Hearing Loss
- ❑ Seasonal Allergies

Neck: ☐**Normal**
- ❑ Neck Mass
- ❑ Swollen Glands

Respiratory: ☐**Normal**
- ❑ Cough
- ❑ Difficulty Breathing
- ❑ Wheezing

Breast: ☐**Normal**
- ❑ Breast Mass
- ❑ Breast Pain
- ❑ Breast Swelling
- ❑ Skin Changes

Cardiovascular: ☐**Normal**
- ❑ Chest Pain
- ❑ Elevated Blood Pressure
- ❑ Shortness of Breath
- ❑ Swelling of Extremities

Gastrointestinal: ☐**Normal**
- ❑ Abdominal Pain
- ❑ Constipation
- ❑ Diarrhea
- ❑ Nausea
- ❑ Vomiting

Genitourinary: ☐**Normal**
- ❑ Blood in Urine
- ❑ Frequency
- ❑ Incontinence
- ❑ Painful Urination

Musculoskeletal: ☐**Normal**
- ❑ Back Pain
- ❑ Joint Pain
- ❑ Joint Swelling

Neurological: ☐**Normal**
- ❑ Dizziness
- ❑ Fainting
- ❑ Numbness
- ❑ Seizures

Psychiatric: ☐**Normal**
- ❑ Anxiety
- ❑ Depression
- ❑ Easily Irritated
- ❑ Memory Loss

Endocrine/Glands: ☐**Normal**
- ❑ Appetite Changes
- ❑ Cold Intolerance
- ❑ Thyroid Problems

Hematology: ☐**Normal**
- ❑ Anemia
- ❑ Blood Clots
- ❑ Easy Bruising
- ❑ Easy Bleeding