MediVis

Adult Intake

(Please print clearly)

Name _____ **Date** _____

Date of birth _____ (M/D/Y) **Sex M F**

Address_____

_____

_____

_____

E-mail Address _____

Home Telephone Number _____ **Work** _____

May we leave messages relating to your visits? Y / N

Which Phone Number? _____

Emergency contact: Name _____

Phone number _____ **Relation**_____

How did you hear about our Clinic? Please check one of the following:

- ❑ **Media/TV Article**
- ❑ **Corporate Health/Wellness Event**
- ❑ **Clinic staff**
- ❑ **Clinic patient**
- ❑ **Other** _____

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Other health care providers you are seeing:

1.	2.	3.
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
(_____)_____	(_____)_____	(_____)_____

What are your health concerns, in order of importance to you:

1. _____
2. _____
3. _____
4. _____
5. _____

If you are female are you currently pregnant? Yes No (Please circle one)

Medical History

How would you describe your general state of health? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses or injuries and any hospitalizations, along with approximate dates.

_____
_____
_____
_____
_____

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Do you have any allergies (medicines, environmental, etc.)?

_____

_____

_____

_____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

_____

_____

_____

_____

Please list past prescription medications.

_____

_____

_____

_____

How many times have you been treated with antibiotics? _____

Do you frequently use any of the following? (circle)

Aspirin / Laxatives / Antacids / Diet pills / Birth control pills/implants/injections

Alcohol—how much/day or week _____
Tobacco—form and amount/day _____
Caffeine—form and amount/day_____
Recreational drugs—what and how often _____

Please indicate what immunizations you have had

☐ DPT (diphtheria, pertussis, tetanus)	☐ Haemophilus influenza B	☐ Hepatitis A
☐ Tetanus booster; when? _____	☐ "Flu"	☐ Hepatitis B
☐ MMR (measles, mumps, rubella)	☐ Polio	☐ Smallpox

Other _____

Please indicate if any caused adverse reactions:

_____

Do you get regular screening tests done by another doctor? (pap, blood tests, etc.)? Y / N

Diet

Do you have any food allergies or intolerances? Please list.

_____

_____

_____

_____

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

_____

_____

_____

_____

Describe a typical day's diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages (and total quantity) _____

Family History

Indicate if a close relative (parent, child, sibling) has had any of the following:

	Please indicate which family member
Allergies	
Asthma	
Heart Disease	
High Blood Pressure	
Cancer	
Diabetes	
Depression	
Other Mental Illness	
Drug Abuse/Alcoholism	
Kidney Disease	
Other	

- ❑ **I don't know my family medical history**

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Environment

Occupation _____

Hobbies _____

Do you exercise regularly? Y / N What do you do for exercise, how much, how often?

_____

_____

_____

_____

Are you exposed to significant tobacco smoke (work, home, etc.)? Y / N
Are you frequently exposed to animals (work, pets, etc.)? Y / N

How is your home heated?

_____

_____

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe.

_____

_____

_____

How would you describe the emotional climate of your home?

_____

_____

_____

How stressful is your work, or other aspects of your life? How well do you handle these stresses?

_____

_____

_____

Is there anything that you feel is important that has not been covered?

_____

_____

_____

For file use only

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Review of Systems

Name: _____ **Date:** _____

Y A condition you have now
N A condition you have NEVER had
P A condition you have had in the past

1. GENERAL				
Weight				
Weight 1 year ago				
Maximum weight				
When				
Height				
Fatigue/Weakness	Y	P	N	
Fever/Chills	Y	P	N	

2. SKIN				
Rashes	Y	P	N	
Eczema, hives	Y	P	N	
Acne, boils	Y	P	N	
Itching	Y	P	N	
Color change	Y	P	N	
Lumps	Y	P	N	
Night sweats	Y	P	N	
Dryness/Moistness	Y	P	N	
Temperature	Y	P	N	
Nail changes	Y	P	N	
Change in mole	Y	P	N	
Skin cancer	Y	P	N	

3. HEAD				
Headache	Y	P	N	
Head injury	Y	P	N	
Dizziness	Y	P	N	

4. EYES				
Impaired vision	Y	P	N	
Glasses/Contacts	Y	P	N	
Eye pain	Y	P	N	
Tearing or dryness	Y	P	N	
Double vision	Y	P	N	
Glaucoma	Y	P	N	
Cataracts	Y	P	N	
Blurring	Y	P	N	
Bothered by sun	Y	P	N	

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Itching	Y	P	N	
Redness	Y	P	N	
Discharge	Y	P	N	
Blind spot	Y	P	N	

5. EARS				
Impaired hearing	Y	P	N	
Earache	Y	P	N	
Dizziness	Y	P	N	
Discharge	Y	P	N	
Infections	Y	P	N	

6. NOSE and SINUSES				
Frequent colds	Y	P	N	
Nose bleeds	Y	P	N	
Stuffiness	Y	P	N	
Hay fever	Y	P	N	
Sinus problems	Y	P	N	

7. MOUTH and THROAT				
Frequent sore throat	Y	P	N	
Sore tongue/mouth	Y	P	N	
Gum problems	Y	P	N	
Hoarseness	Y	P	N	
Dental cavities	Y	P	N	
Loss of taste	Y	P	N	

8. NECK				
Lumps	Y	P	N	
Swollen glands	Y	P	N	
Goiter	Y	P	N	
Pain or stiffness	Y	P	N	

9. RESPIRATORY				
Cough	Y	P	N	
Sputum	Y	P	N	
Spitting up blood	Y	P	N	
Wheezing	Y	P	N	
Asthma	Y	P	N	
Bronchitis	Y	P	N	
Pneumonia	Y	P	N	
Pleurisy	Y	P	N	
Emphysema	Y	P	N	
Difficulty breathing	Y	P	N	
Pain on breathing	Y	P	N	
Shortness of breath	Y	P	N	
Shortness of breath at night	Y	P	N	

Shortness of breath lying down	Y	P	N	
Tuberculosis	Y	P	N	
Tuberculin Test	Y	P	N	
Last Chest -ray				

10. CARDIOVASCULAR				
Heart disease	Y	P	N	
Angina	Y	P	N	
High blood pressure	Y	P	N	
Murmurs	Y	P	N	
Rheumatic fever	Y	P	N	
Chest pain	Y	P	N	
Swelling in ankles	Y	P	N	
Palpitations, fluttering	Y	P	N	
Cyanosis	Y	P	N	
Past ECG	Y	P	N	
Other heart tests				

11. BREASTS				
Do you do self exams?	Y	P	N	
Lumps	Y	P	N	
Pain (or tenderness)	Y	P	N	
Nipple discharge	Y	P	N	

12. GASTROINTESTINAL				
Trouble swallowing	Y	P	N	
Heartburn	Y	P	N	
Change in thirst	Y	P	N	
Change in appetite	Y	P	N	
Nausea	Y	P	N	
Vomiting	Y	P	N	
Vomiting blood	Y	P	N	
Bowel movements - how often?				
Is this a change?	Y		N	
Blood in stool	Y	P	N	
Belching or passing gas	Y	P	N	
Jaundice (yellow skin)	Y	P	N	
Liver disease	Y	P	N	
Gall bladder disease	Y	P	N	
Ulcer	Y	P	N	
Indigestion	Y	P	N	
Diarrhea	Y	P	N	
Rectal bleeding	Y	P	N	
Hemorrhoids	Y	P	N	
Black, tarry stool	Y	P	N	
Abdominal pain	Y	P	N	
Food allergy	Y	P	N	

Hernias	Y	P	N	

13. URINARY				
Pain on urination	Y	P	N	
Increased frequency	Y	P	N	
Frequency at night	Y	P	N	
Inability to hold urine	Y	P	N	
Frequent infections	Y	P	N	
Kidney stones	Y	P	N	
Blood in urine	Y	P	N	
Urgency	Y	P	N	
Hesitancy	Y	P	N	

14. MALE REPRODUCTIVE				
Hernias	Y	P	N	
Testicular masses	Y	P	N	
Testicular pain	Y	P	N	
Are you sexually active?	Y	P	N	
Sexual difficulties	Y	P	N	
Venereal disease	Y	P	N	
Discharge or sores	Y	P	N	
Sexual preference: Heterosexual	Y	P	N	
Bisexual	Y	P	N	
Homosexual	Y	P	N	

15. FEMALE REPRODUCTIVE				
Age menses began				
Average number of days				
Length of cycle				
Bleeding between periods	Y	P	N	
Are cycles regular	Y	P	N	
Pain during intercourse	Y	P	N	
Painful menses	Y	P	N	
Excessive flow	Y	P	N	
PMS	Y	P	N	
Birth control?	Y	P	N	
What type?				
Number of pregnancies				
Number of live births				
Number of miscarriages				
Number of abortions				
Difficulty conceiving	Y	P	N	
Are you sexually active?	Y	P	N	
Sexual difficulties	Y	P	N	
Venereal Disease	Y	P	N	
Sexual preference: Heterosexual	Y	P	N	

Bisexual	Y	P	N	
Homosexual	Y	P	N	
Last menstrual period				
Vaginal discharge	Y	P	N	
Vaginal itching	Y	P	N	
Last PAP - (date)				

16. MUSCULOSKELETAL				
Joint pain or stiffness	Y	P	N	
Arthritis	Y	P	N	
Broken bones	Y	P	N	
Muscle spasms or cramps	Y	P	N	
Weakness	Y	P	N	
Joint swelling	Y	P	N	
Backache	Y	P	N	

17. PERIPHERAL VASCULAR				
Deep leg pain	Y	P	N	
Cold hands/feet	Y	P	N	
Varicose veins	Y	P	N	
Thrombophlebitis	Y	P	N	
Leg cramps	Y	P	N	
Extremity numbness	Y	P	N	
Extremity coldness	Y	P	N	
Extremity swelling	Y	P	N	
Extremity ulcers	Y	P	N	

18. NEUROLOGIC				
Fainting	Y	P	N	
Seizures/Convulsions	Y	P	N	
Paralysis	Y	P	N	
Muscle weakness	Y	P	N	
Numbness or tingling	Y	P	N	
Loss of memory	Y	P	N	
Involuntary movement	Y	P	N	
Loss of balance	Y	P	N	
Speech problems	Y	P	N	

19. ENDOCRINE				
Heat or cold intolerance	Y	P	N	
Thyroid trouble	Y	P	N	
Excessive thirst	Y	P	N	
Excessive hunger	Y	P	N	
Excessive urination	Y	P	N	
Excessive sweating	Y	P	N	
Diabetes	Y	P	N	
Hypoglycemia	Y	P	N	

Hormone therapy	Y	P	N	

20. BLOOD/LYMPHATIC				
Anemia	Y	P	N	
Easy bleeding or bruising	Y	P	N	
Past transfusions	Y	P	N	
Lymph node swelling	Y	P	N	

20. ALLERGIC HISTORY				
Drug sensitivity	Y	P	N	
Reaction to vaccine	Y	P	N	
Allergies? Please list				

21. EMOTIONAL				
Depression	Y	P	N	
Mood swings	Y	P	N	
Anxiety or nervousness	Y	P	N	
Tension	Y	P	N	
Phobias	Y	P	N	
Alcohol/Drug abuse	Y	P	N	
Insomnia	Y	P	N	

22. HOBBIES/HABITS			
Please answer yes (Y) or no (N)			
Do you eat three meals daily?	Y	N	What are your main interests and hobbies?
Do you awake rested?	Y	N	
Do you sleep well?	Y	N	
Do you average 6-8 hours sleep?	Y	N	
Do you enjoy your work?	Y	N	
Do you watch television?	Y	N	
How many hours/day?			
Do you read?	Y	N	
Do you exercise? What forms? How many times/week?	Y	N	
Do you take vacations?	Y	N	
Have you been treated for drug dependency?	Y	N	
Do you use recreational drugs?	Y	N	
Do you use alcoholic beverages?	Y	N	
Have you been treated for alcoholism? How often?	Y	N	