Intake form

Main Line HealthCare
Physician Network

PATIENT INFORMATION

Name:_____

Date: _____

Date of birth: _____

Current Weight: _____ Current Height: _____

Occupation and Employer: _____

_____

Are you currently employed:_____

If not when did you stop? _____

Date of Injury or Onset of Symptoms: _____

Family Physician, Name/Address: _____

_____

_____

Referring Physician: _____

Please list all physician specialists that you are currently seeing: _____

_____

_____

REASON FOR VISIT

PLEASE INDICATE YOUR LEVEL OF PAIN 0-10. 10 BEING THE WORST PAIN YOU HAVE EVER HAD.

1 2 3 4 5 6 7 8 9 10

Reason for your visit:_____

_____

_____

_____

DRUG ALLERGIES

Please list all drug allergies and describe reaction: _____

_____

_____

CURRENT MEDICATIONS

Please list all medical problems with their corresponding medications (ex. Hypertension, diabetes, etc).

Medication	Associated Problems

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Please check or fill in completely.

Social history:

Do you drink alcohol? ☐ No ☐ Yes (Number per day _____)

Do you smoke cigarettes? ☐ No ☐ Yes (Number per day _____)

Do you have significant problems with these other areas?

Weight loss	☐ No	☐ Yes
Loss of appetite	☐ No	☐ Yes
Fever/chills	☐ No	☐ Yes
Double/blurred vision	☐ No	☐ Yes
Ringing in ears	☐ No	☐ Yes
Bloody nose/gums	☐ No	☐ Yes
Sore throat	☐ No	☐ Yes
Chest pain	☐ No	☐ Yes
Palpitations	☐ No	☐ Yes
Shortness of breath	☐ No	☐ Yes
Cough	☐ No	☐ Yes
Speech	☐ No	☐ Yes
Leg/arm weakness	☐ No	☐ Yes
Blood in stool	☐ No	☐ Yes
Constipation/diarrhea	☐ No	☐ Yes
Blood in urine	☐ No	☐ Yes
Abdominal pain	☐ No	☐ Yes
Change in bladder habits	☐ No	☐ Yes
Rashes	☐ No	☐ Yes
Bruises	☐ No	☐ Yes
Headache	☐ No	☐ Yes
Dizziness	☐ No	☐ Yes
Blackouts	☐ No	☐ Yes
Numbness/tingling	☐ No	☐ Yes
Seizures	☐ No	☐ Yes
Pain in other joints?	☐ No	☐ Yes

If yes, please list: _____

_____

Past medical history includes:

High blood pressure	☐ No	☐ Yes
Peptic ulcer	☐ No	☐ Yes
Frequent infections	☐ No	☐ Yes
Bleeding problems	☐ No	☐ Yes
Stroke	☐ No	☐ Yes
Anesthesia problems	☐ No	☐ Yes
Liver disease	☐ No	☐ Yes
Rheumatoid arthritis	☐ No	☐ Yes
Cardiac disease	☐ No	☐ Yes
Angina	☐ No	☐ Yes
Thyroid	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes
Sleep apnea/c-pap	☐ No	☐ Yes
Blood clot	☐ No	☐ Yes
Cancer	☐ No	☐ Yes
Emphysema	☐ No	☐ Yes
Depression/anxiety	☐ No	☐ Yes
Asthma	☐ No	☐ Yes

Other medical conditions:_____

_____

_____

_____

Patient signature Date

_____

Mitesh P. Shah, MD Date