

Dr. Theo Christodoulakis www.onegooddoctor.com

Referred by: _____

Date: _____

General Medical Intake Form

Please be as descriptive as possible

Patient Name: _____ Sex: _____ Age: _____ Occupation: _____

Race: _____ Religion: _____ Practicing: _____ E-mail: _____

Address: _____

Contact Phone numbers: Home: _____ Cell: _____ Work: _____

Contact in case of an emergency: Name & Phone number: _____

Chief Complaint: _____

Secondary Complaint: _____

Past Medical History:

Have you had any other serious Illness or diseases other than the present complain:

Ever been hospitalized?	Reason	When	Where

Medications (include non-prescription) _____ **Allergies:** _____

Supplements

Patient Social History:

Marital Status: Single: __ Married: __ Separated: __ Divorced: __ Widowed: __ Partnership: __

Explain your occupation: _____

Traveled recently/Place: _____ Country/State raised: _____

Use of Alcohol: Never: __ Rarely: __ Moderate: __ Daily: __ Quantity: _____

Use of Tobacco: Never: __ Rarely: __ Moderate: __ Daily: __ Quantity: _____

Use of Caffeine: Never: __ Rarely: __ Moderate: __ Daily: __ Quantity: _____

Use of Drugs: Never: __ Rarely: __ Moderate: __ Daily: __ Quantity: _____

Excessive Exposure at home or work to:

Smoking: __ Fumes: __ Dust: __ Solvents: __ Air-Borne Particles: __ Noise: __

Family Medical History: _____ If you are adopted check here: _____

Age Diseases If deceased, Cause of Death

Father: _____

Mother: _____

Siblings: _____

Grand Parents: _____

Children: _____

Spouse: _____

Favorite Color: _____ **Smell:** _____ **Food:** _____ **Past Time:** _____

REVIEW OF SYSTEMS: (PLEASE INDICATE PERSONAL HISTORY BELOW)

CONSTITUTIONAL SYMPTOMS

Good General Health Lately N Y
 Recent Weight Change N Y
 Fever N Y
 Fatigue N Y

EYES

Eye Disease or Injury N Y
 Wear Glasses/Contacts N Y
 Blurred or Double Vision N Y

EARS/NOSE/MOUTH/THROAT

Hearing Loss or Ringing N Y
 Earaches or Drainage N Y
 Chronic Sinus/Rhinitis Problem N Y
 Nose Bleeds N Y
 Mouth Sores N Y
 Bleeding Gums N Y
 Bad Breath N Y
 Sore Throat/Voice Change N Y
 Swollen Glands in Neck N Y
 Difficulty Swallowing N Y

CARDIOVASCULAR

Heart Trouble N Y
 Chest Pain/Angina Pectoris N Y
 Palpitation (flutters) N Y
 Shortness of Breath N Y
 Walking or Laying Down N Y
 Swelling of Feet/Ankles/Hands N Y
 High Blood Pressure N Y
 Chronic/Frequent Cough N Y
 Cough with Blood N Y
 TB Exposure N Y
 Wheezing N Y
 Asthma N Y
 Last Chest X-ray: _____

MUSCULOSKELETAL

Joint Pain N Y
 Joint Stiffness/Swell N Y
 Weakness of Muscle/Joints N Y
 Muscle Pain or Cramps N Y
 Back Pain N Y
 Cold Extremities N Y
 Difficulty in Walking N Y

ENDOCRINE

Glandular/Hormone Problem N Y
 Excessive Thirst/Urination N Y
 Heat/Cold Intolerance N Y
 Change in Hat/Glove Size N Y
 Skin Becoming Dryer N Y

GENITOURINARY

Frequent Urination N Y
 Burn/Painful Urination N Y
 Blood in Urine N Y
 Chg. in Force/Stream During Urination N Y
 Incontinence/Dribbling N Y
 Kidney Stones N Y
 Sexual Difficulty N Y
 Male-Testicle Pain N Y
 Female-Pain with Periods N Y
 Female - Irregular Periods N Y
 Female-Vaginal Discharge N Y
 Female - # of Pregnancies _____
 Female - # of Miscarriage _____
 Female - Last Pap Smear _____
 Sexually Active N Y
 Birth Con./Protection Descript. _____

INTEGUMENTARY

(Skin/Breast)

Rash or Itching N Y
 Change Hair/Nails N Y
 Change in Skin Color N Y
 Varicose Veins N Y
 Breast Pain N Y
 Breast Lump N Y
 Breast Discharge N Y

PSYCHIATRIC

Memory Loss/Confusion N Y
 Nervousness or Anxiety N Y
 Depression N Y
 Insomnia N Y

INTEGUMENTARY

(Skin/Breast)

Rash or Itching N Y
 Change Hair/Nails N Y
 Change in Skin Color N Y
 Varicose Veins N Y
 Breast Pain N Y
 Breast Lump N Y
 Breast Discharge N Y

HEMATOLOGIC/LYMPHATIC

Slow to Heal Cuts N Y
 Bleeding/Bruise Tendency N Y
 Anemia N Y
 Phlebitis: Blood Clots N Y
 Inflammation Vein N Y
 Past Transfusion N Y
 Enlarged Glands N Y

ALLERGIC (Reaction History)

Penicillin/Other Antibiotics N Y
 Morphine, Demerol N Y
 Other Narcotics N Y
 Novocaine/other Anesthetic N Y
 Aspirin/Other Pain Remedies N Y
 Tetanus antitoxin/other serums N Y
 Other Drugs/Medications N Y
 Known Allergies/Food/Environ. _____

GASTROINTESTINAL

Loss of Appetite N Y
 Change in Bowel Movement N Y
 Nausea or Vomiting N Y
 Frequent Diarrhea N Y
 Painful Bowel Movements N Y
 Constipation N Y
 Abdominal Pain N Y
 Rectal Bleeding N Y
 Blood in Stool N Y
 Hemorrhoids N Y

NEUROLOGICAL

Freq./Recurring Headaches N Y
 Lightheaded/Dizzy N Y
 Convulsion/Seizure N Y
 Numbness or Tingling N Y
 Tremors (Shaking) N Y
 Paralysis N Y
 Head Injury N Y
 Difficulty Walking N Y

IMMUNIZATIONS

Polio N Y
 Flu N Y
 Tetanus N Y
 Date of Last Tetanus Shot: _____
 Hepatitis B N Y
 Diphtheria N Y
 Pertussis N Y
 Rubella N Y
 Measles/Mumps N Y
 Influenza Y N
 Other: _____

NOTES

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature (Parent or Guardian if Patient is a Minor)

Date