

INTAKE QUESTIONNAIRE FORM



Please provide us with the following information.

We will enter this information into your electronic health record.

Please bring a current medication list or all medications to your office visit.

TODAY'S DATE _____

PATIENT DEMOGRAPHICS

Name <i>(last, first, middle initial)</i>		SS#	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth date: / /	Aliases:	
Physical Address	City	State	Zip
Mailing Address	City	State	Zip
Home Phone ()	Work Phone ()	Mobile ()	
Email Address		Primary Phone: <input type="checkbox"/> Home <input type="checkbox"/> Mobile	

GENERAL INFORMATION

Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Legally separated <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Significant other	Birth State
Interpreter Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Preferred Language
English Fluency: <input type="checkbox"/> Good <input type="checkbox"/> Not at all <input type="checkbox"/> Not good <input type="checkbox"/> Very good	Written Language
Ethnicity: <input type="checkbox"/> Mexican American or Chicano <input type="checkbox"/> Other Hispanic, Latino/a, or Spanish Origin <input type="checkbox"/> Cuban <input type="checkbox"/> NOT Hispanic, Latino/a, or Spanish Origin <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Decline to answer	
Religion	Military Status & Branch
	Race

EMERGENCY CONTACT

Contact Name	Primary Phone: <input type="checkbox"/> Home <input type="checkbox"/> Mobile	
Home Phone ()	Work Phone ()	Mobile ()
Contact Address	City	State
Contact Email	Relationship to Patient	
Legal Guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Secondary Contact	Primary Phone: <input type="checkbox"/> Home <input type="checkbox"/> Mobile	
Home Phone ()	Work Phone ()	Mobile ()
Contact Address	City	State
Contact Email	Relationship to Patient	

Legal Guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No
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PATIENT QUESTIONNAIRE

PATIENT NAME _____ DATE OF BIRTH _____

What are we seeing you for today? **Right** **Left** **Knee** **Hip**

Pain scale 1-10? _____

When did the problem start? _____

How did the problem start? _____

Describe the symptoms: (sharp pain, dull ache, numbness, tingling, etc.)

Describe the severity: (mild, moderate, severe, disabling, etc.)

Duration of symptoms: (hours, days, months, years, intermittent, etc.)

Timing of symptoms: (with activity, at night, while typing, etc.)

What makes the problem better? (Rest, heat, ice, medications, etc.)

What makes the problem worse? (Activity, reaching overhead, lifting, etc.)

How far can you tolerate to walk? _____

Do you struggle to put your sock on or tie your shoe on the affected side? **Yes** **No**

Does you hip/knee pain interrupt your sleep? **Yes** **No**

Previous treatment for this problem:

Injections _____ Physical Therapy _____ Medication _____ Surgery _____

Metal allergies? (Necklaces, earrings, etc.) _____ **Known metal:** _____

Allergies to latex or iodine? _____

Review of Symptoms



ENLIFE

Patient Name *(last, first, middle initial)* _____

Date of Birth _____

PLEASE CHECK ALL THAT APPLY

Constitution

- Activity change
- Appetite change
- Chills
- Diaphoresis (Sweating)
- Fatigue
- Fever
- Unexpected weight change

Respiratory

- Apnea
- Chest tightness
- Choking
- Cough
- Shortness of breath
- Stridor
- Wheezing

GU

- Difficulty urinating
- Dyspareunia
(painful sexual intercourse)
- Dysuria (painful urination)
- Enuresis
- Flank pain
- Frequency
- Genital sore
- Hematuria (blood in urine)
- Menstrual problem
- Penile discharge
- Penile pain/swelling
- Pelvic pain
- Scrotal swelling
- Testicular pain
- Urgency
- Urine decreased
- Vaginal bleeding
- Vaginal discharge
- Vaginal pain

Allergy/Immuno

- Environmental allergies
- Food allergies
- Immunocompromised

Neurological

- Dizziness
- Facial asymmetry
- Headaches
- Light-headedness
- Numbness
- Seizures
- Speech difficulty
- Syncope (fainting)
- Tremors
- Weakness

HENT

- Congestion
- Dental problem
- Drooling
- Ear discharge
- Ear pain
- Facial swelling
- Hearing loss
- Mouth sores
- Nosebleeds
- Postnasal drip
- Rhinorrhea (runny nose)
- Sinus pain
- Sinus pressure
- Sneezing
- Sore throat
- Tinnitus (ringing in ears)
- Trouble swallowing
- Voice change

Cardiovascular

- Chest pain
- Leg swelling
- Palpitations

GI

- Abdominal distention
- Abdominal pain
- Anal pain
- Blood in stool
- Constipation
- Diarrhea
- Nausea
- Rectal pain
- Vomiting

Hematologic

- Adenopathy
(swollen lymph nodes)
- Bruises/bleeds easily

Muscular

- Athralgias (joint pain)
- Back pain
- Gait problem
- Joint swelling
- Myalgias (muscle pain)
- Neck pain
- Stiffness

Psychiatric

- Agitation
- Behavior problem
- Confusion
- Decreased concentration
- Dysphoric mood
- Hallucinations
- Hyperactive
- Nervous/anxious
- Self injury
- Sleep disturbance
- Suicidal ideas

Eyes

- Eye discharge
- Eye itching
- Eye pain
- Eye redness
- Photophobia
(sensitive to light)
- Visual disturbance

Endocrine

- Cold intolerance
- Heat intolerance
- Polydipsia
(increased thirst)
- Polyphagia
(increased appetite)
- Polyuria
(increased urination)

Skin

- Color change
- Pallor
- Rash
- Wound

Other symptoms _____

PRIMARY CARE PHYSICIAN

Primary Care Physician

Address City

Phone Fax

EMPLOYMENT

Occupation

- Disabled Full time Not employed On active military duty Part time
 Retired Self employed Student - full time Student - part time Unknown

Employer Employer Phone

Employer Address

INSURANCE

Do you have Medical Insurance: Yes No Are you the insurance holder? Yes No

Group# Subscriber#

Insurance Type: Personal/Family Workers' comp Third party Additional type

Who is responsible for this account? Self Spouse Father Mother Other

Insured Name (if different than patient) SS# Birth Date

Address (if different than patient)

City State Zip County

Home Phone () Work Phone () Mobile Phone ()

Employer

Address

City State Zip County

MEDICAL HISTORY Have you had any of the following? (Check all that apply)

Common Problems

- | | | |
|---|---|--|
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD) | <input type="checkbox"/> Heart valve disease |
| <input type="checkbox"/> Blood coagulation disorder | <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Chronic kidney disease | <input type="checkbox"/> Gastroesophageal reflux disease (GERD) | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> (CHF) Congestive heart failure | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Sleep apnea |

Medical History

- | | | |
|---|---|--|
| <input type="checkbox"/> Deep vein thrombosis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Transient ischemia attack (TIA) |
| <input type="checkbox"/> History of radiation therapy | <input type="checkbox"/> Pulmonary embolism | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Myocardial infarction | <input type="checkbox"/> Stroke | <input type="checkbox"/> Ulcers (GI) |

Anesthesia History

- | | | |
|---|--|--|
| <input type="checkbox"/> Delayed emergence | <input type="checkbox"/> Malignant hyperthermia | <input type="checkbox"/> Pseudocholinesterase deficiency |
| <input type="checkbox"/> Difficult intubation | <input type="checkbox"/> Motion sickness | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Intraoperative awareness | <input type="checkbox"/> Post-operative nausea and vomiting (PONV) | <input type="checkbox"/> Spinal headache |

SURGICAL HISTORY Have you had any of the following? (Check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> AICD implants | <input type="checkbox"/> C-section | <input type="checkbox"/> Nephrostomy |
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Dental surgery | <input type="checkbox"/> Orthopedic surgery |
| <input type="checkbox"/> Anal/rectal surgery | <input type="checkbox"/> Esophagus surgery | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Aortic aneurysm repair | <input type="checkbox"/> Eye surgery | <input type="checkbox"/> Peripheral vascular access |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Fracture surgery | <input type="checkbox"/> Prostate surgery |
| <input type="checkbox"/> AV fistula/graft | <input type="checkbox"/> Heart valve surgery | <input type="checkbox"/> Shoulder surgery |
| <input type="checkbox"/> Back surgery | <input type="checkbox"/> Hernia repair | <input type="checkbox"/> Sinus surgery |
| <input type="checkbox"/> Bladder surgery | <input type="checkbox"/> Hip surgery | <input type="checkbox"/> Spendectomy |
| <input type="checkbox"/> Bowel surgery | <input type="checkbox"/> Implanted pump | <input type="checkbox"/> Stomach surgery |
| <input type="checkbox"/> Breast biopsy | <input type="checkbox"/> Indwelling vascular access | <input type="checkbox"/> Thyroid surgery |
| <input type="checkbox"/> CABG | <input type="checkbox"/> Kidney transplant | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Carotid endarterectomy | <input type="checkbox"/> Knee surgery | <input type="checkbox"/> Tracheostomy |
| <input type="checkbox"/> Cataract removal/IOL implant | <input type="checkbox"/> Lumbar laminectomy | <input type="checkbox"/> Tubal ligation |
| <input type="checkbox"/> Cervical spine surgery | <input type="checkbox"/> Lung surgery | <input type="checkbox"/> TURP |
| <input type="checkbox"/> Cholecystectomy | <input type="checkbox"/> Lymph node biopsy | <input type="checkbox"/> Vascular surgery |
| <input type="checkbox"/> Cosmetic surgery | <input type="checkbox"/> Mastectomy | <input type="checkbox"/> VP shunt |
| <input type="checkbox"/> Craniotomy | <input type="checkbox"/> Nephrectomy (kidney removal) | <input type="checkbox"/> Weight loss surgery |

SOCIAL HISTORY

Tobacco use? <input type="checkbox"/> YES <input type="checkbox"/> NO	Start Date	Quit Date
	Type(s) used: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Pipe <input type="checkbox"/> Cigars	
	Packs per day _____ Years _____	
Smokeless tobacco use? <input type="checkbox"/> YES <input type="checkbox"/> NO	Start Date	Quit Date
	If yes, Type: <input type="checkbox"/> Snuff <input type="checkbox"/> Chew	
Alcohol Use? <input type="checkbox"/> YES <input type="checkbox"/> NO	Drinks per week: () glasses of wine () cans of beer () shots of liquor () standard drinks or equivalent	
Drug use? <input type="checkbox"/> YES <input type="checkbox"/> NO		

SOCIAL ASSESSMENT

Do you live at home? YES NO

Current living situation: Home Nursing home Assisted living Homeless

Do you have a care partner who is willing to assist you with your needs? YES NO

Do you have adequate transportation available for expected visits? YES NO

Do you feel safe in your environment? YES NO

Activity level: Very little activity Daily activities Occasional exercise Extensive exercise

Light exercise Regular exercise

Are you on a special diet? YES NO

IMPLANTS

Do you have any implants? YES NO If YES, Permanent Temporary

	Type

HEALTH MAINTENANCE

Have you ever had?	Y	N	Year	Physician/Facility
Pap Smear				
Mammogram				
Colonoscopy				
HPV Vaccine				
Influezna (flu vaccine)				
DEXA scan (bone density)				

Have you ever had an abnormal pap smear? NO YES If Yes, When? _____

Have you ever had an abnormal mammography? NO YES If Yes, When? _____

Have you ever had an abnormal colonoscopy? NO YES If Yes, When? _____

Outpatient Medical Information Release



Name _____ Date of Birth: ____/____/____

RELEASE OF INFORMATION

I authorize the verbal release of information related to my outpatient visits at Enloe Medical Center.

This information may be released to:

- Spouse _____
- Child(ren) _____
- Other _____
- Information is not to be released to anyone other than me.

I request that the following information be excluded from this release of information and that it not be shared with those listed above.

- _____
- No Exclusions

MESSAGES

Please call me at (_____) _____ - _____. If you are unable to reach me via phone:

- You may leave a detailed message
- Please leave a message asking me to return your call
- Do not leave a message

This release ***specifically excludes*** any psychiatry and psychology evaluations/records that are further restricted by HIPAA regulations.

I understand that it is my responsibility to update Enloe Medical Center with any changes to whom I authorize verbal release of my health information. This Release of Information will remain in effect for one year from the date below or until terminated by me in writing via an updated version of this form.

Patient Signature: _____ Date: ____/____/____

Witness Signature: _____ Date: ____/____/____

Patient Information