For Your Health,
Julie Chicks, MD

Intake History

Name	Date of birth
Why are you coming to see Dr. Chicks?	
Current Medications, Dose, and Directions. Include over-the-counter & supplements. Attach a list if you prefer.	
List medications you are allergic to (or caused problems). **Describe the reaction.** Attach a list if you prefer.	
List your food and/or environmental allergies. **Describe the reaction.** Attach a list if you prefer.	
SOCIAL HISTORY and HEALTH BEHAVIORS	
Do you have an advanced directive? YES NO Do you want to information about advanced directives? YES NO	
Do you have a faith tradition? YES NO If yes, what faith	
What type of work do you do? Who is your employer?	
Last year of education completed _____ or degree earned- HS Diploma Technical AD BA/S Master Doctorate	
What are your hobbies?	
Marital Status- Never Living with partner Married Divorced Widowed Remarried	
Do you have children? NO YES List names & ages	
Who lives in your household?	
Do you restrict any foods/products from your diet? -	
Describe your typical diet-	
Do you exercise? NO YES Explain further-	
Do you routinely (100%) use: Helmets YES NO; Seat Belts YES NO	
Does your home have (as required by law) Smoke Detectors YES NO Carbon Monoxide Detectors YES NO	
Are there any guns or rifles in your home? NO YES If yes-are they stored in a locked cabinet? YES NO	
Do you use sunscreen? YES NO	
Do you use caffeine-containing products? YES NO If yes-describe the type, amount, and frequency of use.	
Do/did you use nicotine products? Never Current Former If current/former- how many years of use, type, amount, frequency of use, (and when you quit).	
Do or have you used alcohol? Never Current Former If you do or have-describe the type, amount, and frequency of alcohol use (and when you quit).	
Are you or others concerned about your alcohol use? YES NO	
Do you get upset if anyone says you drink too much? YES NO	
Have you ever tried to cut back but it didn't last? YES NO	
Do you have a "hair of the dog" sometimes because of not feeling well after drinking? YES NO	
Do or have you used marijuana, or marijuana like substances, or street drugs? Never Current Former If current/former- how many years of use, type, amount, frequency of use, (and when you quit).	

Do or have you used pain, anxiety, or sleeping pills not prescribed to you or more then prescribed? Never Current Former If current/former- how many years of use, type, amount, frequency of use (and when you quit).
Do you have tattoos, piercings or dermal implants? YES NO If yes-indicate location/type on the separate diagram.

Name and Date of Birth **DOS**

Some of the following questions are very personal in nature. Remember ALL of your medical information shared with and/or discussed with the doctor and the staff (at any time) is always held in the strictest confidence.
How do you identify your gender/sexuality? Female Male Transgender Heterosexual Gay Lesbian Bisexual Transsexual Asexual Not Sure
In your lifetime, how many partners have you had? Zero One If more than 1, how many? (estimate if not sure)
Are you currently sexually active? YES NO If yes, is the relationship monogamous? YES NO
Have you been bullied or abused emotionally, and/or physically by a family member or someone else? YES NO
Do you feel safe from verbal, emotional and/or physical abuse currently? YES NO
Have you ever been sexually assaulted or molested? YES NO If you feel comfortable, explain more about your answers.

VACCINATIONS

Circle the vaccines you have received and list the approximate date.

MMR		HPV		Influenza		Pneumovax 23	
Td/ Tdap		Hepatitis B		Shingles (Zoster)		Prevnar 13	
Chicken Pox		Hepatitis A		Meningitis			

REVIEW OF SYSTEMS

Have you recently developed, or been experiencing increased difficulty related to any of the symptoms listed below? If yes, circle and provide more details.

General Health:	**Eyes, Ears, Nose, Throat, and Mouth cont.**
weight problems/change	hearing loss
appetite change	ringing in the ears
sleep problems/change	poor sense of smell/taste
fatigue	bleeding from nose
other concerns about health **What?**	sinus pain or drainage
	sore throat
Skin:	dental problems
itching	sores in mouth
yellow skin or eyes	other concerns **What?**

new or changing moles	
moles of unusual color or shape	**Heart and Lungs:**
patches/areas of rough skin	chest pain/discomfort
sweating	rapid heartbeat for no reason
changes of skin nails or hair	shortness of breath
change in voice	“charley horses” in legs while walking
sores which don’t heal	decreased or poor ability to exercise
skin infections	becoming short of breath while lying down
hives	waking up short of breath
other concerns **What?**	cough with or without sputum
	blood in sputum
Eyes, Ears, Nose, Throat, and Mouth:	wheezing or tightness in chest
neck pain	snoring
eye pain	fainting
ear pain/pressure	other concerns **What?**
abnormal vision	

Esophagus, Stomach, Intestines:	**Genital and Urinary Systems cont:**
problems swallowing	blood or Coca-Cola colored urine
feeling as if food gets stuck	vaginal discharge/odor/itch
heartburn	uncomfortable or painful intercourse
sour taste in mouth	discharge from penis
bad breath	rash or sores on genitals
food coming up in your throat	problems with orgasm
nausea or vomiting	erectile dysfunction
abdominal pain/cramps	lump in breast(s) or testicle(s)
diarrhea and/or constipation	irregular menstrual periods
bloody, mahogany, black, or mucousy stools	last period (mm/dd/yy)
painful bowel movements	average days between periods (1^{st} day to 1^{st} day)
other concerns **What?**	describe flow (# of days, heavy days, etc.)
	pain before and/or during period
Muscles, Joints, and Bones:	other concerns **What?**
swelling of legs/feet	
muscle aches/tenderness	**Endocrine System:**
joint pain	very hungry
lumps on bones or joints	very thirsty
bone pain	very frequent urination
joint swelling	lump in front of neck
red or warm joints	pain in front of neck
pain in back of heel	hot flashes
pain in bottom of foot	infertility
poor flexibility	other concerns **What?**
changes in color of fingers	
other concerns **What?**	**Immune System:**
	frequent infections
Neurological System:	unusual lumps/bumps under skin
headaches	unexplained fevers
problems driving at night	other concerns **What?**
weakness in an area(s) of body or limb	
numbness in an area(s) of body or limb	**Mental Health:**

pins and needles sensations	anxiety or panic attack
difficulty speaking intermittent or otherwise	repetitive thoughts or repetitive actions
dizzy or lightheaded	racing thoughts
twitches	flashbacks
tremors	difficulty with concentration
balance problems or falls	little interest in sex
problems with walking	little interest in being with or around people
concerns about memory	irritability
other concerns **What?**	depression
	mood swings
Genital and Urinary Systems:	feeling sad or tearful
leakage or urine or stool	feeling it wouldn't matter (to you) if you died
painful and/or frequent urination	feeling as if life is not worth living
having to urinate urgently	thinking of harming yourself / harming someone else
delay or weakness of stream	other concerns **What?**

SURGICAL/PROCEDURAL and HOSPITALIZATION HISTORY Attach a list if you prefer.
Include approximate date, which surgery(ies) or procedure(s), and the name of physician(s) or facility(ies).

FAMILY MEDICAL HISTORY Attach a list if you prefer.
Are all of your biologic Grandparents, Parents, Aunts, Uncles, Siblings, and Children still living? If not, explain who has passed, at what age and why (as far as you know).

PERSONAL MEDICAL HISTORY AND FAMILY MEDICAL HISTORY Attach a list if you prefer.
Check the PH box if you have or have had the condition. Check the FH box if someone in your family has or has had the problem.

PH	FH	Condition/Issue	Date of Onset (only for you)	PH	FH	Condition/Issue	Date of Onset (only for you)
		Environmental Allergies				Diabetic Eye Disease	
		Hives				Glaucoma	
		Overweight or Obese				Cataract	
		Organ transplant				Near or Far Sighted	

		Congenital/Birth Defects				Other Eye/Ear Disorder	
		What?				**What?**	
		Eczema				Mouth/Dental Problems	
		Psoriasis				**What?**	
		History of Blistering (2nd degree) Sunburn				Head Trauma/Injury	
						What?	
		Acne				Anemia	
		Skin Infections				Bleeding Disorder	
		Cellulitis				Factor 5 Leiden	
		Actinic Keratosis				Clots in Legs or Lungs	
		Ulcers of Feet and/or Legs				Blood Transfusion	
		Other Skin Disorder				Other Blood Disorder	
		What?				**What?**	
		Nasal polyps				High Cholesterol	
		Sinusitis				Low or High LDL circle one	
		Other Nose/Sinus Disorder				Low or High HDL circle one	
		What?				High Triglycerides	
		Hearing loss				Heart Attack/Stroke circle one	
		Wax in Ear Canals				Coronary Artery Disease	
		Ear Infections				Carotid Artery Disease	
		Tinnitus (Ringing)				Peripheral Artery Disease	
		Meniere's Disease				Abnormal Heart Rhythm	
		Macular Degeneration				Swelling of Legs/Feet	

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 Physician initials _____

PERSONAL MEDICAL HISTORY AND FAMILY MEDICAL HISTORY (cont.) Attach a list if you prefer.
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PH	FH	Condition/Issue	Date of Onset (only for you)	PH	FH	Condition/Issue	Date of Onset (only for you)
		Heart Valve Problem				Tubal Pregnancy	
		Heart Murmur				Pregnancy Loss Which trimester?	
		Congestive Heart Failure				Pregnancy Problems	
		Congenital Heart Disease				**What?**	
		Aortic Aneurysm				Infertility	
		Erectile Dysfunction				Other Reproductive Tract Disorder	
		Other Heart/Vascular Disorder				**What?**	
		What?				Osteoarthritis/DJD	
		Asthma				Where?	

		Exercise Induced Asthma				Joint Surgery	
		Reactive Airway Disease				Which?	
		Emphysema/COPD				Tendonitis	
		Other Respiratory Disorder				Where?	
						Bursitis	
		What?				Where?	
		Obstructive Sleep Apnea				Sciatica	
		Narcolepsy				Plantar Fasciitis	
		Other Sleep Disorder				Osgood-Schlatter Disease	
		What?				Thrombophlebitis	
		GERD				Varicose Veins	
		Ulcer				Other Muscle/Joint Disorder	
		Irritable Bowel Syndrome					
		Crohn’s Disease				**What?**	
		Ulcerative Colitis				Carpal Tunnel Syndrome	
		Hepatitis A or B				Fibromyalgia	
		Hepatitis C non-carrier				Tremor	
		Hepatitis C chronic carrier				Benign Positional Vertigo	
		Hemochromatosis				Multiple Sclerosis	
		Pancreatitis				Parkinson’s Disease	
		Abnormal Liver Tests				Peripheral Neuropathy	
		Other Digestive Disorder				Diabetic Neuropathy	
		What?				Seizure Disorder	
		Urinary Incontinence				Dementia	
		Bladder Infections				Alzheimer’s Disease	
		Frequent Urination				Stroke/CVA	
						Brain Aneurysm/Rupture	
		Overactive Bladder				Other Neurological Disorder	
		Kidney Stones					
		Diabetic Kidney Disease				**What?**	
		Cystic Kidney Disease				Attention Deficit Disorder	
		Other Urinary System Disorder				Bipolar I	
						Bipolar II	
		What?				Bipolar Type Disorder	
		Vaginal Infections				Anxiety general, social,	
		Endometriosis				Panic Attacks	

PERSONAL MEDICAL HISTORY AND FAMILY MEDICAL HISTORY (cont.)
Check the PH box if you have or have had the condition. Check the FH box if someone in your family has or has had the problem.

PH	FH	Condition/Issue	Date of Onset (only for you)	PH	FH	Condition/Issue	Date of Onset (only for you)
		Depression				Low Testosterone	
		Obsessive Compulsive Disorder				Other Endocrine Disorder	
						What?	
		Personality Disorder Disorder				Chicken Pox	
						Shingles (Zoster)	
		Post Traumatic Stress Disorder				Infectious Mononucleosis	
						Lyme's Disease	
		Bulimia				Tuberculosis (TB)	
		Anorexia Nervosa				Sexually Transmitted Disease	
		Other Mental Health Disorder					
						HIV/AIDS	
		What?				Other Infectious Disorder	
		Hypothyroidism (Hashimoto's)				**What?**	
		Hyperthyroidism (Grave's)				Obstructive Sleep Apnea	
		Hypercalcemia				Narcolepsy	
		Rheumatoid Arthritis				Other Sleep Disorder	
		Lupus				**What?**	
		Raynaud's Syndrome				Lung Cancer	
		Sjogren's Syndrome				Colon or Rectal Cancer	
		Other Autoimmune Disorder				Breast or Ovarian Cancer	
						Cervical Cancer	
		What?				Melanoma Skin Cancer	
		Pre-diabetes				Testicular Cancer	
		Gestational Diabetes				Prostate Cancer	
		Diabetes Type I				Other Cancer	
		Diabetes Type II				**What type?**	
		Gout					

SCREENING TESTS – when was your last and/or first of the tests listed below? (Approximately)

Test	Date	Test	Date	Test	Date
Colonoscopy		Prostate test		Sugar	
Mammogram		Bone Density			
Pap Smear		Cholesterol			

Is there anything else I should know about you? Is there any other topic you want to discuss?
Explain here-

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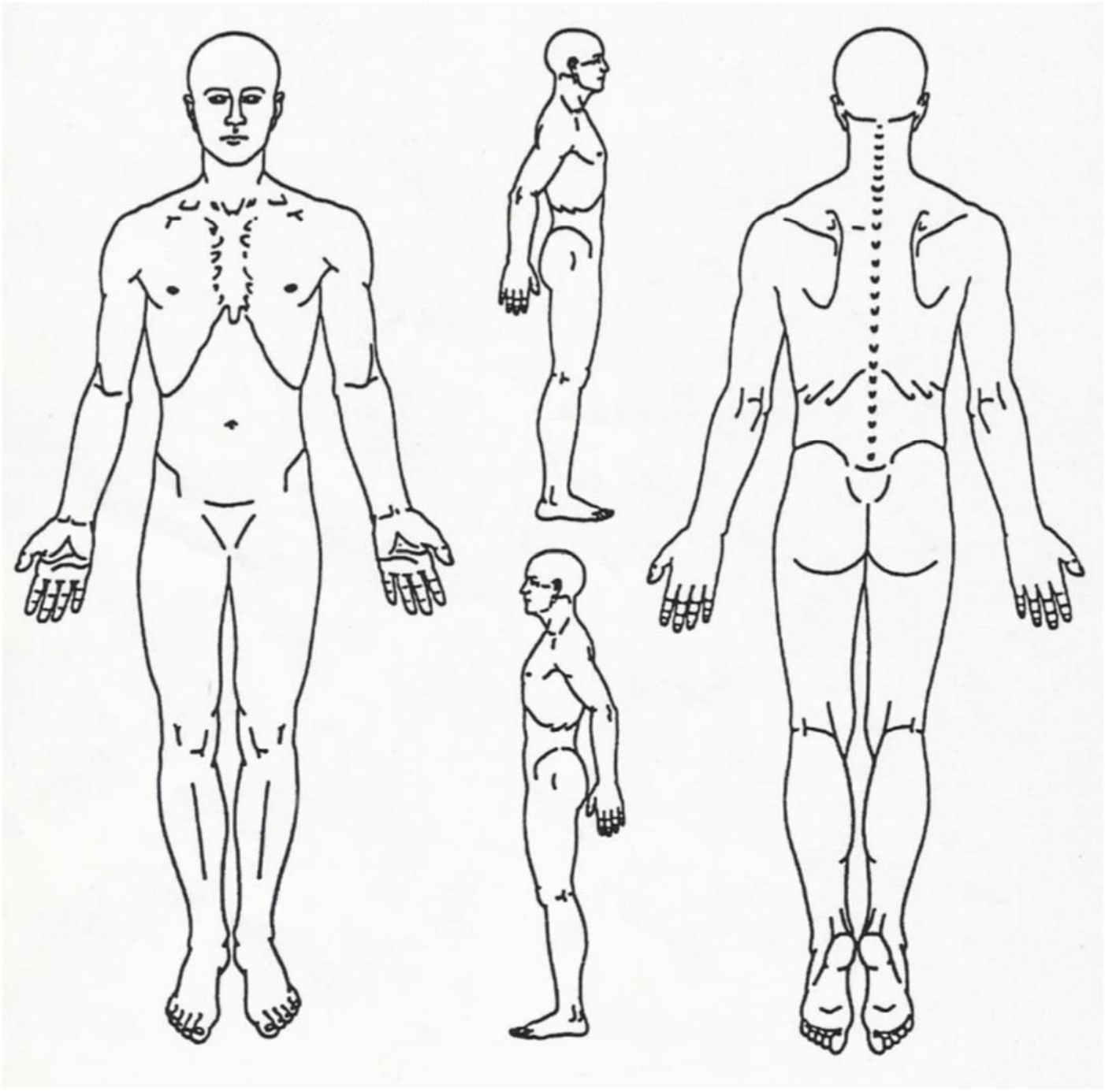

Indicate the location of your piercings, tattoos and scars. Describe below.

physician initials _____