Patient Name: _____ Nickname: _____

Date of Birth: _____ Today's Date: _____

ALLERGIES

(List name and reaction)

Medications/Drugs	Type of Reaction

Food/Environment	Type of Reaction

MEDICATION LIST *(Please bring all medications with you to your appointment)*

(Please include all prescription & non-prescription, medications, vitamins and herbal supplements)

Name of Medication	Dose	# Per Day

SURGICAL PROCEDURES OR HOSPITALIZATIONS *(Please list type/reason and year of surgery or hospitalization)*

Hospitalization/Surgeries	Reason/Type of Surgery	Date

Patient Identification - Write in or attach patient label

Name:

MRN#:

CSN#:

Age /Sex:

HISTORY INTAKE FORM

MultiCare

87-0303-6 (Rev. 12/21)

MEDICAL HISTORY

Please check all that apply

EARS/NOSE THROAT	Current	Past	Never
Headaches			
Visual Problems			
Fainting			
Dizziness			
Seizure			
Stroke			
Ear Trouble			
Hearing Loss			
Sinus Trouble			
Stuffy Nose			
Nose Bleeds			
Allergy			
Hoarseness			
PULMONARY/LUNGS			
Cough			
Wheezing			
Pleurisy			
Pneumonia			
Tuberculosis			
Shortness of Breath			
Night Sweats			
Chest Pain			
Coughed up Blood			
Emphysema/COPD			
Asthma			
G.I./STOMACH			
Trouble Swallowing			
Change in Appetite			
Indigestion			
Heartburn			
Nervous Stomach			
Ulcers			
Vomiting Blood			
Bloody or Dark Stool			
Abdominal Pain			
Colitis			

GI/STOMACH Con't.	Current	Past	Never
Nausea			
Diarrhea			
Constipation			
Hemorrhoids			
Bowel Irregularity			
Gallbladder Trouble			
Hepatitis			
Liver Disease			
SKIN			
Change in Moles or Warts			
Itching/Rash/Hives			
Acne			
Tumor or Swelling			
Skin Cancer			
HEART			
Heart Trouble			
Heart Murmur			
Rheumatic Fever			
Palpitation			
Irregular Heart Beat			
Tire Easily			
Angina/Chest Pain			
Enlarged Heart			
High Blood Pressure			
Abnormal EKG			
Frequent Ankle Swelling			
BONES/JOINTS/MUSCLES			
Arthritis			
Back Pain			
Bursitis			
Muscle Cramps			
Numbness			
Varicose Veins			
Muscle Weakness			
Phlebitis/Blood Clots			
Polio			

ENDOCRINE	Current	Past	Never
Diabetes			
Hypoglycemia			
Thyroid Trouble			
Goiter			
Hot Flashes			
Weakness/Fatigue			
Sudden Weight Gain/Loss			
Abnormal Cholesterol			
Trouble Sleeping			
KIDNEY/UROLOGY			
Kidney Trouble			
Bladder Infection			
Incontinence			
Difficulty Urinating			
Prostate Trouble			
Infertility			
Impotence			
Sexual Problems			
Sexual Transmitted Diseases			
EMOTIONAL/PSYCHOLOGICAL			
Emotional Illness			
Difficulty Sleeping			
Excessive Worry or Anxiety			
Severe Tension			
Feeling Worthless			
Constant Unhappiness			
Mood Swings			
Panic Attacks			
OTHER			
Blood Disorders			
Anemia			
Cancer			
Breast Pain			
Breast Abnormality			

Patient Name/MRN#: _____

FAMILY HISTORY

Are you adopted? ❑ Yes ❑ No

Did/does anyone in your family have any of the following conditions? (Check all that apply)

	Mother	Father	Sister	Brother	Maternal Grand-mother	Maternal Grand-father	Paternal Grand-mother	Paternal Grand-father	Daughter	Son	Other
Allergies											
Arthritis											
Asthma											
Back Problems											
Blood Diseases											
Cancer											
COPD											
Diabetes											
Drug/Alcohol Abuse											
Emphysema											
Genetic Disorders											
Stomach Problems											
Kidney Disease											
Heart Problems											
Hypertension											
Lipids											
Neurological Disorders											
Obesity											
Psychiatric											
Scoliosis											
SIDS											
Stroke											
Tuberculosis											
Thyroid Disorder											
Other											
No Significant Family History											
STATUS											
Alive											
Deceased											
Unknown											

Patient Name/MRN #: _____

SOCIAL HISTORY

Persons living in your household: *(list all persons in your household)*

Marital Status: ❑ Separated ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Partner

Alcohol **Do you drink alcohol?** ❑ Never ❑ Occasionally ❑ Daily
If yes, what kind? ❑ Beer ❑ Wine ❑ Liquor
Number of drinks per day: _____

Tobacco **Do you currently use tobacco?** ❑ Yes ❑ No
If yes, how many years? _____
What form of tobacco? ❑ Pipe ❑ Cigarettes ❑ Chew ❑ Cigar
Number per day? _____
Quit? _____ Quit date? _____
Does anyone in your household smoke? ❑ Yes ❑ No

Drug Use *(Do not include prescription or over-the-counter medications)* ❑ Never ❑ No current use ❑ Occasional ❑ Daily
Uses per week? _____ Uses per day? _____ Types of drugs? _____

Sexual Activity: *(check all that apply)* ❑ Inactive ❑ Occasionally ❑ Regularly ❑ Multiple partners ❑ Male partner ❑ Female partner
Do you practice safe sex? ❑ Yes ❑ No

PLEASE MARK YES OR NO TO THE FOLLOWING

	No	Yes	Comments
Been in the military			
Received a blood transfusion			
Drink beverages with caffeine			How much?
Are you exposed to hazards at work			
Have difficulty sleeping			
Have too much stress in your life			
Weigh too much or too little			
Eat a special diet *(high protein, vegan)*			
Have back problems			
Exercise regularly			
Always use a seat belt in a car			
Do breast or testicular exams regularly			
Home has working smoke detector			
Are your immunizations up-to-date			
Have regular screening exams			
Do you get an annual flu shot			
Do you eat a balance diet			

Advanced Directives: Do you have a ❑ Power of Attorney ❑ Living Will

FOR FEMALE PATIENTS ONLY

Date last menstruated: _____ Menopause: _____ Age: _____
Any menstrual problems? ❑ Yes ❑ No Period every _____ days
Number of pregnancies: _____ Number of births: _____ Number of miscarriages: _____
Difficulty with pregnancy: _____ With labor:_____ With delivery:_____
Check if you have had: ❑ D & C ❑ Hysterectomy ❑ Toxemia ❑ Cesarean Section
Are you on birth control? ❑ Yes ❑ No If yes, what type:_____
When was your last Mammogram?_____

CARE TEAM AND COMMUNICATIONS

Other Providers in my Care	Specialty

Patient Name/MRN #: _____