Southern Maine Integrative Health Center
Adult Intake Form

Patient name:	Birthdate: / /	Age:	Date: / /
Address:			
City:	State/zip:		
Home telephone: ( )	Work telephone: ( )		
Employer:	Insurance company:		
Insurance policy number:	Insurance group number:		
Emergency contact:			
Relationship:			
Home phone: ( ) work phone: ( )			
Why have you come to the office today?			
Is this a new problem?			
Please describe your problem, including where it is, how severe it is, how long it has lasted.			
Medication allergies: If any, please list allergy and type of reaction.			

Personal profile

Marital status: ___ married ___living with partner ___single ___ widowed ___divorced
Number of people in household:
Current or most recent job:
Travel outside of the u.s.?

Current medications

(including hormones, vitamins, herbs, nonprescription and prescription medications)

Drug name	dosage	Who prescribed	Drug name	dosage	Who prescribed

Name:	Date:

gynecological history

	Physician's notes
Last normal menstrual period (first day): / /	
Age periods began:	
Length of periods (Number of days of bleeding):	
Number of days between periods:	
Any recent changes in periods?	
Are you currently sexually active?	
Present method of birth control:	
Have you ever used an intrauterine device (IUD) or birth control pills?	
If yes, for how long?	
When was your last pap test?	
What was the result?	
Have you ever had an abnormal pap test?	
Do you do regular breast self examinations?	
When was your last mammogram?	
What was the result?	
Any abnormal mammograms?	
Have you ever had a bone density test?	

Family history

Mother- __living __deceased-cause:	Father- __living ___deceased-cause:
Children: number living: Number deceased: cause(s)/age(s):	

illness	**yes**	**Which relative(s) and age of onset**	**Physician's notes**
diabetes			
stroke			
Heart disease			
Blood clots in lungs or legs			
High blood pressure			
High cholesterol			
Osteoporosis (weak bones)			
hepatitis			
HIV/AIDS			
tuberculosis			
Birth defects			
Drinking or drug problems			
Breast cancer			
Colon cancer			

Ovarian cancer			
Patient name:		Date:	

Family history (continued)

	yes	no	Physician's notes
Uterine cancer			
Mental illness/depression			
Alzheimer's disease			
other			

Social history

	yes	no	Physician's notes
ever smoked? Currently smoking?			
Alcohol:			
recreational drug use?			
Seat belt use?			
Regular exercise:			
Health hazards at home and at work?			
Have you been sexually abused, threatened, or hurt by anyone?			

Operations and hospitalizations

reason	date	hospital

Injuries

type	date	type	date

Immunizations/tests

	date		date
Tetanus-diptheria booster		Influenza vaccine (flu shot)	
Hepatitis a vaccine		Hepatitis b vaccine	
Varicella vaccine		Pneumococcal vaccine	

Measles-mumps-rubella (MMR) vaccine		Tuberculosis (TB) skin test: result:	
Name:		Date:	

Personal past history of illness

Major illness	Yes (date)	no	Not sure	Physician's notes
asthma				
Pneumonia/lung disease				
Kidney infections/stones				
tuberculosis				
Sexually transmitted disease				
HIV/aids				
Heart attack/problems				
diabetes				
High blood pressure				
stroke				
Rheumatic fever				
Blood clots in lungs or legs				
Eating disorders				
Collagen vascular disease (lupus)				
chickenpox				
cancer				
Reflux/hiatal hernia/ulcers				
Depression/anxiety				
anemia				
Blood transfusions				
Seizures/convulsions/epilepsy				
Bowel problems				
glaucoma				
cataracts				
Arthritis/joint pain/back problems				
Broken bones				
Hepatitis/yellow jaundice/liver disease				
Thyroid disease				
Gallbladder disease				
headaches				
other				

Name:	Date:

Review of systems

Please check (x) if any of the following symptoms apply to you now or since childhood

	now	past	Not sure	Physician's notes
1. constitutional				
Weight loss				
Weight gain				
Fever				
fatigue				
Change in height				
2. eyes				
Double vision				
Spots before eyes				
Vision changes				
Glasses/contacts				
3. ear, nose, and throat				
earaches				
Ringing in ears				
Hearing problems				
Sinus problems				
Sore throat				
Mouth sores				
Dental problems				
4. cardiovascular				
Painful breathing				
Chest pain or pressure				
Difficulty breathing on exertion				
Rapid or irregular heartbeat				
5. respiratory				
Wheezing				
Spitting up blood				
Shortness of breath				
Chronic cough				
6. gastrointestinal				
Frequent diarrhea				
Bloody stool				
Nausea/vomiting/indigestion				
constipation				
Involuntary loss of gas or stool				
7. genitourinary				
Blood in urine				
Pain with urination				

Name:	Date:

	now	Past	Not sure	Physician's notes
Strong urgency to urinate				
Frequent urination				
Incomplete emptying				
Involuntary/unintended urine loss				
Urine loss when coughing or lifting				
Abnormal bleeding				
Painful periods				
Premenstrual syndrome (PMS)				
Painful intercourse				
fibroids				
infertility				
DES exposure				
Abnormal Vaginal Discharge				
8. Musculoskeletal				
Muscle weakness				
Muscle or joint pain				
9. skin				
rash				
sores				
Dry skin				
moles				
10. breasts				
Pain in breast				
Nipple discharge				
lumps				
11. neurologic				
dizziness				
seizures				
numbness				
Trouble walking				
Severe memory problems				
Frequent or severe headaches				
12. psychiatric				
Depression or frequent crying				
Severe anxiety				

Name:	Date:

Review of systems (continued)

	now	past	Not sure	Physician's notes
13. endocrine				
Hair loss				
Heat/cold intolerance				
Abnormal thirst				
Hot flashes				
14.hematologic/lymphatic				
Frequent bruises				
Cuts do not stop bleeding				
Enlarged lymph nodes (glands)				
15. allergies (food and other environmental)				
Please list all allergies and type of reaction:				

Form completed by: ___patient ___office nurse/ma ___physician ____other			
Signature of patient:			
Date reviewed by physician with patient:		Physician signature:	
Annual review of history:			
Date:	Physician sign:	Date:	Physician sign:
Date:	Physician sign:	Date:	Physician sign: