Ithaca Free Clinic

Medical Intake Form

MR# _____

Name (Last, First):_____ Date:_____

Known Allergies (Food, Medication, Other):_____

Please mark the any of the following problems you are currently experiencing

General

- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Headaches
- ☐ Loss of Sleep
- ☐ Mental Illness
- ☐ Tremors
- ☐ Weight Gain/Loss
- ☐ Head Trauma/Injury

Respiratory

- ☐ Chest Pain
- ☐ Chronic Cough
- ☐ Difficulty Breathing
- ☐ Respiratory Infection
- ☐ Wheezing
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Other _____

Muscle / Bone / Joint

- ☐ Chronic Pain
  Where:_____
  How Long: _____
- ☐ Disc Herniation
- ☐ Fracture/Dislocation
- ☐ Arthritis
- ☐ Spinal Deformity
- ☐ Joint Pain
- ☐ Other _____

Gastrointestinal

- ☐ Ulcer/Upper GI Bleeding
- ☐ Lower GI Bleeding
- ☐ Hemorrhoids
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Abdominal Pain
- ☐ Bloody/Tarry Stool
- ☐ Vomiting
- ☐ Nausea
- ☐ Other _____

Cardiovascular

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Palpitations
- ☐ Pacemaker
- ☐ Bleeding Disorder
- ☐ Blood Clot/Phlebitis
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Circulation Problems
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Other _____

Genitourinary

- ☐ Urinary Tract Infection
- ☐ Bladder Infection
- ☐ Kidney Stone
- ☐ Painful Urination
- ☐ Increased Frequency of
- ☐ Change in Flow/Force of
- ☐ Other _____

Habits	No	Yes	
Smoking	☐	☐	Packs/day _____
Alcohol	☐	☐	Drinks/wk _____
Exercise	☐	☐	Hrs/wk _____
Sleep		☐	Hrs/wk _____
Prolonged Sitting	☐	☐	Hrs/wk _____
Salty foods	☐	☐	_____
Healthy diet	☐	☐	_____

Other Conditions

- ☐ Alcoholism
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Goiter
- ☐ STD

Comments (further explanation of any of the above): _____

_____

Hospitalizations (Include surgeries, drug/alcohol rehabilitations)

Date	Hospital	Reason	Doctor

Family History

Father ☐ Alive ☐ Deceased

Medical problems: _____

Mother ☐ Alive ☐ Deceased

Medical problems: _____

Siblings ☐ Alive ☐ Deceased

Medical problems: _____

☐ Family history unknown

☐ Significant other conditions in family history _____

Female History

Menstrual cramps

☐ Mild ☐ Moderate ☐ Severe

Are you pregnant?

☐ No ☐ Yes - Months _____

Last menstrual period: _____

Pregnancy history: Children _____

☐ Live births _____ ☐ Still births _____

☐ Miscarriages _____ ☐ Abortions _____

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Present complaint and reason for seeking care: _____

How long have you had this problem? _____

Is this problem getting worse? ☐ No ☐ Yes

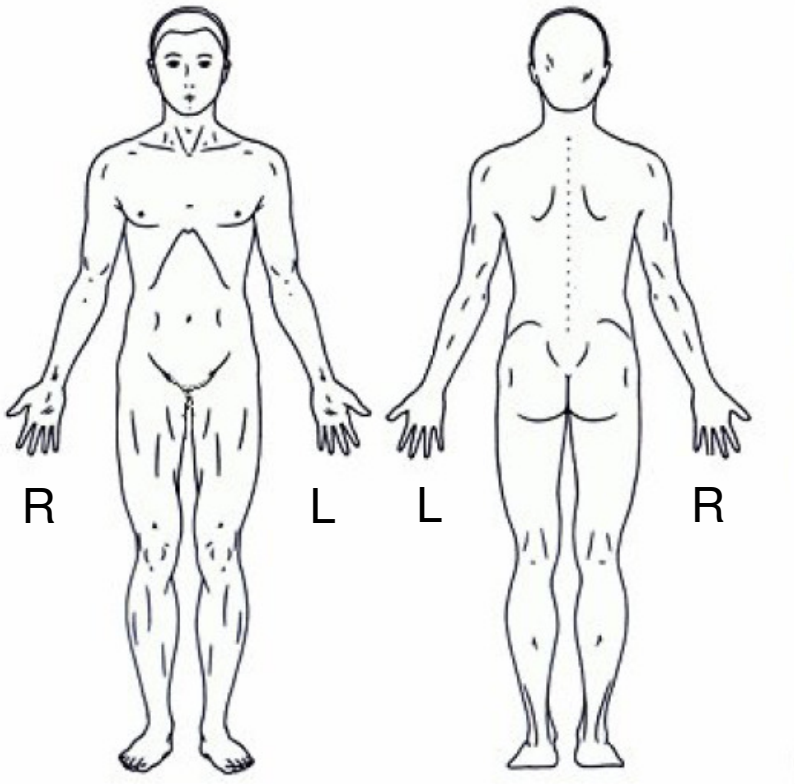
Have you seen anyone else regarding this complaint? ☐ No ☐ Yes

If so, whom? _____

Have you received any medical tests for this conditions (X-Rays, blood tests, etc)? ☐ No ☐ Yes _____

Other health problems you may have and would like us to address: _____

Please draw location of your presenting complaint on the body outlines below



No Pain ——————— Worst Pain Possible

Please mark on the level of your pain on the scale above

Is there anything else you would like us to know that may help us with your visit? _____

_____

_____

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

Patient Signature _____ **Date** _____

Office use only:

I have reviewed this medical intake form with the patient _____ Date: _____

Signature, title