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| **Adult New/Existing Patient Intake Form** |
| **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M/F** **Race: Black African American Hispanic Non hispanic White Asian Other****Home Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Home phone/Cell phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Pharmacy Name/Phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Insurance Name/Member Id:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Please list ALL active treating physicians (i.e. pulmonologist, oncologist, internist, cardiologist, etc…)Doctor’s Name: Specialty: Doctor’s Name: Specialty: Doctor’s Name: Specialty: Doctor’s Name: Specialty:  |

Do you currently smoke? □ Y □ N If no, previously? □ Y □ N Years smoked Packs/day

Do you use other tobacco products? □ Y □ N Consume alcohol? □ Y □ N If yes, drinks/week:

Do you have any allergies to medications or other substances (pets, food, etc.)? □Y □N

If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis):

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| --- | --- | --- | --- | --- |
| Allergy | Reaction |  | Allergy | Reaction |
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**Please refer to our website:** [**https://www.rybsteinmedical.com/**](https://www.rybsteinmedical.com/)

**\*Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing, and correspondence.**

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| **Health Issues** Have you EVER had any of the following? |  |
| Asthma/Breathing Problems........................ | □ Y | □ N | Heart Disease/Disorder .............................. | □ Y | □ N |
| Arthritis........................................................ | □ Y | □ N | Lung Disorder............................................. | □ Y | □ N |
| Bleeding/Clotting Disorder........................... | □ Y | □ N | Liver Disease .............................................. | □ Y | □ N |
| Blood Pressure Disorder............................... | □ Y | □ N |  Neurological Disorder/Chronic Headaches . | □ Y | □ N |
| Blood Transfusion ........................................ | □ Y | □ N | Psychiatric Disorder/Illness......................... | □ Y | □ N |
| Bowel/Stomach Problems............................ | □ Y | □ N | Pulmonary Embolism/DVT ......................... | □ Y | □ N |
| Cancer.......................................................... | □ Y | □ N | Stroke......................................................... | □ Y | □ N |
| Cholesterol Disorder .................................... | □ Y | □ N | Seizure or Epilepsy ..................................... | □ Y | □ N |
| Diabetes....................................................... | □ Y | □ N | Thyroid Disorder ........................................ | □ Y | □ N |
| Eye Disorder (i.e. Glaucoma, cataract) ......... | □ Y | □ N | Urinary/Kidney Disorder ............................. | □ Y | □ N |

**If Relevant:** Gynecological Issues………….. □ Y □ N

Please list any other medical illnesses or problems and provide details for any of the above conditions:

Please list all past surgeries and hospitalizations and the approximate date.

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| Procedure/ Hospitalization | Date | Complications |
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Please list ALL of your current medications, including over the counter medications, supplements, and herbs:

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| --- | --- |
| Medication Name | Dose |
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| --- | --- |
| Medication Name | Dose |
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| **Review of Systems** |  |  |  |
| Please indicate ALL that you have experienced within the past 6 – 12 months. |
| **Constitutional** |  |  |  |
| □Y□N | Fever | □Y□N | Fatigue | □Y□N | Weight Gain ( Lbs) | □Y□N Sleep Disturbances |
| □Y□N | Chills | □Y□N | Feeling Poorly | □Y□N | Weight Loss ( Lbs) | □ Other: |
|  | □Y□N | Sweats | □Y□N Unexp. Weight Change |  |
| **Head, Eyes, Ears, Nose, and Throat** |
| □Y□N | Vision Problem | □Y□N | Red Eyes | □Y□N | Congestion | □Y□N | Hoarseness |
| □Y□N Decreased Hearing□Y□N Double Vision□Y□N Light Sensitivity□Y□N Itchy Eyes**Cardiovascular** | □Y□N | Eye Pain | □Y□N | Snoring | □Y□N Ringing in Ears |
| □Y□N | Runny Nose | □Y□N | Dry Mouth | □Y□N Vertigo |
| □Y□N | Neck Stiffness | □Y□N | Flu-Like Symptoms | □Y□N Ear-ache |
| □Y□N | Nosebleed | □Y□N | Sore Throat | □Y□N Other: |
| □Y□N | Chest Pain | □Y□N | Cold Extremities | □Y□N | Irregular Heart Rhythm |  |
| □Y□N | Palpitations | □Y□N | Cold Hands or Feet | □Y□N | Other: |  |
| □Y□N | Leg Swelling | □Y□N | Leg Pain w/ Walking |  |  |
| **Respiratory** |  |  |  |
| □Y□N | Shortness of Breath | □Y□N | Wheezing | □Y□N | Coughing Up Blood | □ |
| □Y□N | Cough | □Y□N | Shortness of Breath | □Y□N | Coughing Up Sputum |  |
| □Y□N | Rapid Breathing | □Y□N | Chest Congestion | □ Other: |  |
| **Gastrointestinal** |  |  |  |
| □Y□N | Abdominal Pain | □Y□N | Diarrhea | □Y□N | Change in Bowels | □Y□N Painful Swallowing |
| □Y□N | Blood in Stool | □Y□N | Black/Tarry Stools | □Y□N | Vomiting Blood | □ Other: |
| □Y□N | Vomiting | □Y□N | Decreased Appetite | □Y□N | Bowel Incontinence |  |
| □Y□N | Nausea | □Y□N | Yellow Skin | □Y□N | Rectal Pain |  |
| □Y□N | Constipation | □Y□N | Trouble Swallowing | □Y□N | Heartburn |  |
| **Dermatology / Skin**  |  |  |  |
| □Y□N Rash | □Y□N Skin Wound | □Y□N Unusual Growth | □Y□N Skin Cancer |
| □Y□N Dry Skin | □Y□N Change in A Mole | □Y□N Itching | □ Other: |
| **Psychiatric** |  |  |  |
| □Y□N Depression | □Y□N Anxiety | □Other: |  |
| **Endocrine** |  |  |  |
| □Y□N Excessive Thirst | □Y□N Heat Intolerance | □Y□N Changes- Skin |  |
| □Y□N Cold Intolerance | □Y□N Changes- Hair | □ Other: |  |

Patient Signature: Date: