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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: