SCHNEIDER MEDICAL GROUP, PA

History Intake Form

(Please Print)

How Did You
Hear About Us: ____________________________

Patient Name: ____________________________

Date of Visit: ____________________________

Date of Birth: _____________Age:___________

Briefly State the reason for the visit:

____
____
____
____
____

Physician Use Only - History and Present:

1. ____
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2. ____
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3. ____
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4. ____
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5. ____
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Schneider MEDICAL GROUP

SCHNEIDER MEDICAL GROUP, PA

Review of Symptoms

(Please Print)

EYES	NO	YES	EXPLAIN
Blindness			
Cataracts			
Glaucoma			
Wear Glasses			
EARS	**NO**	**YES**	**EXPLAIN**
Hearing aids			
Nose Sinuses			
Allergic rhinitis			
Sinus infections			
MOUTH/THROAT/TEETH	**NO**	**YES**	**EXPLAIN**
Dentures			
Mouth Ulcers			
CARDIOVASCULAR	**NO**	**YES**	**EXPLAIN**
Aneurysm			
Angina			
Myocardial infarction			
DVT			
Irregular heart rhythm			
Hypertension			
Murmur			
Cholesterol problems			
Other Heart disease			
RESPIRATORY	**NO**	**YES**	**EXPLAIN**
Asthma			
Bronchitis/emphysema			
Pleuritic			
Pneumonia			

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Review of Symptoms

(Please Print)

NEUROLOGICAL	NO	YES	EXPLAIN
Epilepsy			
Seizures			
Severe headaches, migraines			
Stroke			
TIA			
ENDOCRINE	**NO**	**YES**	**EXPLAIN**
Goiter			
Thyroid disease			
Hyperthyroidism			
Hypothyroidism			
Thyroiditis			
Diabetes mellitus type 1			
Diabetes mellitus type 2			
HEME/ONC	**NO**	**YES**	**EXPLAIN**
Anemia			
Cancer			
INFECTIOUS	**NO**	**YES**	**EXPLAIN**
HIV			
STDs			
Tuberculosis (diagnosis)			
Tuberculosis (expossure)			
GASTROINTESTINAL	**NO**	**YES**	**EXPLAIN**
Cirrhosis			
Ulcer			
GERD			
Hiatal hernia			
Gallbladder disease			
Heartburn			
Hemorrhoids			
Hepatitis			
Jaundice			
Colon Polyps			

Schneider MEDICAL GROUP

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Review of Symptoms
(Please Print)

GENITOURINARY	**NO**	**YES**	**EXPLAIN**
Hernia			
Incontinence			
Kidney Stones			
Other Kidney disease			
STDs			
UTIs			
MUSCULOSKELETAL	**NO**	**YES**	**EXPLAIN**
Arthritis			
Rheumatoid			
Osteo			
Gout			
Musculoskeletal injury/trauma			
Fibromyalgia			
SKIN	**NO**	**YES**	**EXPLAIN**
Dermatitis			
Moles			
Skin Cancer			
Psoriasis			
Eczema			
Other Skin Conditions			
CUSTOM ITEMS	NO	YES	EXPLAIN
Irritable bowel syndrome			
Obesity			
Colitis			
Rare cancer			
Other			

Schneider MEDICAL GROUP

SCHNEIDER MEDICAL GROUP, PA
Past Medical History
(Please Print)

CHILDHOOD DISEASES	NO	YES	YEAR
Measles			
Mumps			
Rubella			
Chicken Pox			
Whooping Cough			
Menengitis			
Pneumonia			
Asthma			
Eczema			
Chronic Allergies			
Other:			
HAVE YOU EVER HAD/BEEN DIAGNOSED WITH:	**NO**	**YES**	**WHEN**
Hypertension			
Diabetes: Adult Onset or Insulin Dependent			
Cholesteral Problems			
Cancer			
TB			
Diverticulosis			
Ulcer Disease			
Inflamatory Bowel Disease: Ulcerative Colitis or Crohn's Disease			
Irritable Bowel Syndrome			
Gluten Sensitivity			
Thyroid Disease: overactive or underactive			
Cardiac Disease: Mitral Regurgitation or Angina			
Asthma			
COPD			
Head Trauma			
Headaches			
Stroke			
Seizures			

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SCHNEIDER MEDICAL GROUP, PA
Past Medical History Cont.
(Please Print)

PREVENTATIVE TESTS	NO	YES	DATE TEST	LAST TEST
Last Physical Exam				
Bone density				
Colonoscopy				
Cardiac stress test				
Hepatitis C Screen				
HIV screen				
Mammogram				
Pelvic and Pap smear				
PSA				
EKG				
Flu shot				
Pneumovax 23 pneumonia vaccine				
Prevnar 13 pneumonia vaccine				
Shingles vaccine				
Shingrex				
Zostavax				

VACCINES/IMMUNIZATION	DATE
Tetanus-diphtheria; Tetanus-Diphtheria-Pertussis (TD/Tdap)	
Pneumococcal Vaccine - Pneumoax 23, Prevnar 13	
Influenza TIV LAIV	
Hepatitis A and B	
Measles/Mumps/Rubella (MMR)	
Varicella (Chickenpox)	
Haemophilus Influenza Type B (Hib)	
Human Papillomavirus (HPV) Vaccine	
TB skin test	
Typhoid	
YOUR BLOOD TYPE	

Schneider MEDICAL GROUP

SCHNEIDER MEDICAL GROUP, PA

Past Medical History Cont.

(Please Print)

HOSPITALIZATION	REASON	APPROXIMATE Month/Day/Year
SURGICAL PROCEDURES	**REASON**	**APPROXIMATE Month/Day/Year**

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SCHNEIDER MEDICAL GROUP, PA
Lifestyle and Social History
(Please Print)

ALCOHOL	**NO**	**YES**	**TYPE/AMOUNT/HOW OFTEN/HOW MANY YEARS**
Do not drink			
Drink daily			
Frequently drink			
History of alcoholism			
Occasional drink			
DRUG ABUSE	**NO**	**YES**	**TYPE/AMOUNT/HOW OFTEN/HOW MANY YEARS**
IV drug use			
Illicit drug use			
No illicit drug use			
CARDIOVASCULAR	**NO**	**YES**	**TYPE/AMOUNT/HOW OFTEN/HOW MANY YEARS**
Eat healthy meals			
Regular exercise			
Take daily aspirin			
SAFETY	**NO**	**YES**	**TYPE/AMOUNT/HOW OFTEN/HOW MANY YEARS**
Household smoke detector			
Keep firearms in the home			
Wear seat belts			
SEXUAL ACTIVITY	**NO**	**YES**	**TYPE/AMOUNT/HOW OFTEN/HOW MANY YEARS**
Exposure to STI			
Homosexual encounters			
Not sexually active			
Safe sex practices			
Sexually active			
TOBACCO/VAPOR NICOTINE	**NO**	**YES**	**PACK PER DAY/HOW MANY YEARS**
Never smoked			
Current every day smoker			
Current occasional smoker			
Former smoker			
Heavy tobacco smoker			
Light tobacco smoker			

Schneider MEDICAL GROUP

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Family History
(Please Print)

GENERAL	NO	YES	RELATIONSHIP	ALIVE (AGE)	DECEASED (AGE)
No health concerns					
Arthritis					
Asthma					
Bleeding disorder					
CAD less than age 55					
COPD					
Diabetes					
Heart attack					
Heart disease					
High cholesterol					
Hypertension					
Mental illness					
Osteoporosis					
Stroke					
CANCER	**NO**	**YES**	**RELATIONSHIP**	**ALIVE (AGE)**	**DECEASED (AGE)**
Breast cancer					
Colon cancer					
Colon poloyps					
Ovarian cancer					
Uterine cancer					
Other cancer					
ADDITIONAL FAMILY HISTORY			RELATIONSHIP	**ALIVE (AGE)**	**DECEASED (AGE)**

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Allergies

(Please Print)

ALLERGIES:	**NO**	**YES**	**REACTION**
Sulfa			
Penicillin			
Codeine			
ACE Inhibitor			
OTHER DRUGS:			
Name:			
Name:			
ENVIRONMENTAL ALLERGIES:	NO	YES	REACTION
Name:			
Name:			

PRESCRIPTION MEDICATIONS	**DOSE**	**TIMES PER DAY**	**STARTED**
SUPPLEMENTS	**DOSE**	**TIMES PER DAY**	**STARTED**
OTC (OVER THE COUNTER)	**DOSE**	**TIMES PER DAY**	**STARTED**

FAVORITE DRUG STORE	**ADDRESS**	**PHONE#**	**FAX#**