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:

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History and Present: Physician Use Only - Patient Proceed to Next Page

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Review of Symptoms

EYES	YES	NO	EXPLAIN
Blindness			
Cataracts			
Glaucoma			
Wear Glasses			
Other			
EARS	**YES**	**NO**	**EXPLAIN**
Hearing Aids			
Nose Sinuses			
Allergic Rhinitis			
Sinus Infections			
Other			
MOUTH/THROAT/TEETH	**YES**	**NO**	**EXPLAIN**
Dentures			
Mouth Ulcers			
Other			
CARDIOVASCULAR	**YES**	**NO**	**EXPLAIN**
Aneurysm			
Angina (chest pain)			
Myocardial Infarction			
DVT Deep vein thrombosis)			
Irregular Heart Rhythm			
Hypertension			
Murmur			
Cholesterol problems			
Other			
RESPIRATORY	**YES**	**NO**	**EXPLAIN**
Asthma			
Bronchitis/emphysema			
Pleuritis			
Pneumonia			
COPD			
Chronic Cough			
Other			
NEUROLOGICAL	**YES**	**NO**	**EXPLAIN**
Epilepsy			
Seizures			
Severe Headaches/Migraines			
Stroke			
TIA			
Other			
ENDOCRINE	**YES**	**NO**	**EXPLAIN**
Goiter			
Thyroid Disease			
Thyroiditis			
Diabetes Mellitus Type 1			
Diabetes Mellitus Type 2			

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Review of Symptoms Cont.

HEME/ ONC	YES	NO	EXPLAIN
Anemia			
Cancer			
Blood Disease			
Bleeding Disorder			
Other			
INFECTIOUS	**YES**	**NO**	**EXPLAIN**
HIV			
STD's			
Tuberculosis (Diagnosed)			
Tuberculosis (Exposed)			
Hepatitis			
Other			
GASTROINTESTINAL	**YES**	**NO**	**EXPLAIN**
Cirrhosis			
Ulcer			
GERD/ Heartburn			
Hiatal Hernia			
Gallbladder Disease			
Hemorrhoids/ Rectal Bleeding			
GASTROINTESTINAL Cont.	**YES**	**NO**	**EXPLAIN**
Jaundice			
Colon Polyps			
Gluten Sensitivity			
Irritable Bowel Syndrome			
Ulcerative Colitis			
Crohn's Disease			
Other			
GENITOURINARY	**YES**	**NO**	**EXPLAIN**
Inguinal Hernia			
Incontinence			
Kidney Stones			
Recurrent UTI's			
Other			
MUSCULOSKELETAL	**YES**	**NO**	**EXPLAIN**
Arthritis			
Rheumatoid Arthritis			
Osteoarthritis			
Gout			
Musculoskeletal injury/trauma			
Fibromyalgia			
Autoimmune Disease			
Other			
SKIN	**YES**	**NO**	**EXPLAIN**
Dermatitis			
Moles/ Skin Cancer			
Psoriasis			
Eczema			

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Past Medical History

CHILDHOOD DISEASE	YES	NO	EXPLAIN
Measles			
Mumps			
Rubella			
Chicken Pox			
Whooping Cough			
Meningitis			
Pneumonia			
Asthma			
Chronic Allergies			
Other			
PREVENTATIVE TESTS	**YES**	**NO**	**DATE OF TEST**
Last Physical Exam			
Bone Density			
Colonoscopy			
Cardiac Stress Test			
Hep C Screen			
HIV Screen			
Mammogram			
Pelvic Exam			
Pap Smear			
PSA Screen			
EKG			
Other			

IMMUNIZATIONS/VACCINES	DATE
Tetanus-diphtheria; Tetanus-Diphtheria-Pertussis (TD/Tdap)	
Pneumococcal Vaccine- Pneumovax 23, Prevnar 13	
Influenza TIV LAIV	
Hepatitis A and B	
Measles/Mumps/Rubella (MMR)	
Varicella (Chicken Pox)	
Haemophilus Influenza Type B (Hib)	
Human Papilloma Virus Vaccine (HPV)	
TB Skin Test	
Typhoid	
Shingles Vaccine- Shingrex, Zostavax	
Other	
Your Blood Type	

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Past Medical History Cont.

HOSPITALIZATIONS	REASON	APPROXIMATE DATE
SURGERIES	**REASON**	**APPROXIMATE DATE**

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Lifestyle and Social History

ALCOHOL	YES	NO	Type/Amount/How Often/How Many Years
Do Not Drink			
History of Alcoholism			
Drinks:			
-Occasional			
-Frequently			
-Daily			
TOBACCO	**YES**	**NO**	**Pack Per Day/ How Many Years**
Never Smoked			
Former Smoker			
Current Smoker			
VAPOR NICOTINE	**YES**	**NO**	**Type/Amount/How Often/How Many Years**
Never Smoked			
Former Smoker			
Current Smoker			
DRUG ABUSE	**YES**	**NO**	**Type/Amount/How Often/How Many Years**
IV Drug			
Illicit Drug Use			
CARDIOVASCULAR	**YES**	**NO**	**Type/Amount/How Often/How Many Years**
Eat Healthy Meals			
Regular Exercise			
Daily Aspirin			
SAFETY	**YES**	**NO**	**Type/Amount/How Often/How Many Years**
Household Smoke Detector			
Firearms in the home			
Wears seat belts			
SEXUAL ACTIVITY	**YES**	**NO**	**Type/Amount/How Often/How Many Years**
Exposure to STI			
Homosexual Encounters			
Sexually active			
Safe sex practices			
Birth control			
Not sexually active			

Marital Status: ____

Occupation: ____

Highest Level of Education: ______________________________________

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Family History

RELATIONSHIP	*STATUS	*AGE	COMMENTS
Mother			
Father			
Brother(s)			
Sister(s)			
Maternal Uncle(s)			
Maternal Aunt(s)			
Maternal Grandmother			
Maternal Grandfather			
Paternal Uncle(s)			
Paternal Aunt(s)			
Paternal Grandmother			
Paternal Grandfather			
Children			
Other Blood Relative			

*Status-Alive or Deceased.
*Age- current age if alive or age of death if deceased.

Please add any additional information you would like the doctor to know:

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Allergies and Medications

ALLERGIES	YES	NO	REACTION
Sulfa			
Penicillin			
Codeine			
Ace Inhibitors			
Other Drugs:			
ENVIRONMENTAL ALLERGIES	**YES**	**NO**	**REACTION**

PRESCRIPTION/OTC MEDICATIONS	Dose	Times Daily	Started
SUPPLEMENTS	**Dose**	**Times Daily**	**Started**

Preferred Pharmacy	Address	Phone Number