HEMAL J SHAH, MD PC

PATIENT CLINICAL INTAKE FORM

PATIENT NAME: _____ DATE OF VISIT: _____

DATE OF BIRTH: _____

PAST MEDICAL HISTORY

HEART PROBLEMS	
Congestive Heart Failure	□
Heart Attack	□
Heart Murmur	□
High Blood Pressure	□
High Cholesterol	□
Irregular Heartbeat (Atrial Fibrillation)	□

LUNG PROBLEMS	
Asthma	□
Chronic Obstructive Pulmonary Disease	□
Emphysema	□
Pneumonia	□
Pulmonary Embolism	□

GASTROINTESTINAL PROBLEMS	
Cirrhosis	□
Gastric Ulcer	□
Gastroesophageal Reflux Disease	□
Hepatitis	□

ENDOCRINE PROBLEMS	
Diabetes, Type I or II	□
Thyroid Disorder: Type: _____	□

MUSCULOSKELETAL	
Osteoarthritis	□
Osteoporosis	□

BLOOD DISORDERS	
Anemia	□
Bleeding Disorder	□
Blood Transfusion	□
HIV Positive	□

NEUROLOGICAL	
Alzheimer's Disease	□
Cerebral Aneurysm	□
Peripheral Neuropathy	□
Seizure Disorder	□
Stroke	□
TIA	□

URINARY PROBLEMS	
Kidney Infection (pyelonephritis)	□
Kidney Stones	□
Prostate Enlargement	□
Urinary Tract Infection	□

CANCER	
Type: _____	□
Type: _____	□

VASCULAR	
Abdominal Aortic Aneurysm (AAA)	□
Carotid Artery Disease	□
Peripheral Arterial Disease (PAD) [ulcers/muscle pain]	□
Leg Swelling	□
Varicose Veins	□
End Stage Renal Disease (ESRD on HD)	□

ANESTHESIA
Have you ever had a reaction to anesthesia?
Yes □ No □
Please Describe:
_____
_____
_____

PAST SURGICAL HISTORY : *(Please list all previous surgeries)*

	Date of Surgery	Procedure Performed	Surgeon's Name
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Patient Name: ______________________________ Date of Birth: ___________________________

MEDICATION LIST

(Please include prescriptions, over the counter, and herbal medications you are taking)

If additional space is required, please attach your medication list to this form.

Medications	Dosage	Times Taken Per Day	Date Started	Date Stopped

Patient Name: _____ Date of Birth: _____

DRUG ALLERGIES AND REACTIONS:

Drug Name	Allergic Reaction

Are you allergic to latex? Circle One: YES NO

FAMILY MEDICAL HISTORY *(Please list any medical conditions in your family)*

Relationship to Patient	Living/Deceased	Age	Medical Conditions
Mother			
Father			
Grandmother			
Grandfather			
Brother			
Sister			
Child			

SOCIAL HISTORY *(Have you ever used the following?)*

Tobacco Use	Circle One: Never Current Former	
Amount Used:	Age Started:	Age Stopped:
Specify Dates if known:		

Alcohol Use	Circle One: Never Current Former	
Amount Used:	Age Started:	Age Stopped:
Specify Dates if known:		

Recreational Drug Use	Circle One: Never Current Former	
Amount Used:	Age Started:	Age Stopped:
Specify Dates if known:		

Regular Exercise: Circle one: YES NO How Often? _____

Patient Name: _____ Date of Birth: _____

DIALYSIS INFORMATION: (If applicable)

Type: Circle One: HEMO-DIALYSIS PERITONEAL (PD)

Days: Circle One: Mon Tue Wed Thu Fri Sat

Dialysis Center: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____

Nephrologist: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

REVIEW OF SYSTEMS (ROS): *To be completed by patient*

ARE YOU EXPERIENCING ANY OF THE FOLLOWING? PLEASE CIRCLE Y FOR YES AND N FOR NO

CONSTITUTIONAL		
Weight Gain	Y	N
Weight Loss	Y	N
Fever	Y	N
Chills	Y	N
Fatigue	Y	N
Loss of Appetite	Y	N
Night Sweats	Y	N
Other _____	Y	N

EYES		
Pain	Y	N
Discharge	Y	N
Light Sensitivity	Y	N
Blurred Vision	Y	N
Double Vision	Y	N
Other _____	Y	N

EAR, NOSE, THROAT		
Sore Throat	Y	N
Hoarseness	Y	N
Ringing in Ears	Y	N
Nose Bleeds	Y	N
Hearing Loss	Y	N
Other _____	Y	N

BREASTS		
Breast Discharge	Y	N
Other _____	Y	N

CARVIOVASCULAR		
Chest Pain	Y	N
Palpitations	Y	N
Calf Pain	Y	N
Leg Pain	Y	N
Shortness of Breath	Y	N
Other _____	Y	N

RESPIRATORY		
Wheeze	Y	N
Cough	Y	N
Bloody Sputum	Y	N
Other _____	Y	N

GASTROINTESTINAL		
Abdominal Pain	Y	N
Nausea	Y	N
Vomiting	Y	N
Diarrhea	Y	N
Constipation	Y	N
Heartburn	Y	N
Blood in Stool	Y	N
Other _____	Y	N

GENITOURINARY		
Frequency	Y	N
Incontinence	Y	N
Flank Pain	Y	N
Blood in Urine	Y	N
Other _____	Y	N

INTEGUMENT		
Rash	Y	N
Moles	Y	N
Sores	Y	N
Breast Discharge	Y	N
Other: _____	Y	N

NEUROLOGICAL		
Headaches	Y	N
Confusion	Y	N
Dizziness	Y	N
Memory Loss	Y	N
Seizure	Y	N
Other _____	Y	N

MUSCULOSKELETAL		
Muscle Pain	Y	N
Joint Pain	Y	N
Joint Swelling	Y	N
Weakness	Y	N
Poor Balance	Y	N
Other _____	Y	N

ENDOCRINE		
Excessive Sweating	Y	N
Excessive Thirst	Y	N
Excessive Heat	Y	N
Excessive Cold	Y	N
Other _____	Y	N

PSYCHIATRIC		
Anxiety	Y	N
Depression	Y	N
Stress	Y	N
Other _____	Y	N

HEME-LYMPH		
Easy Bruising	Y	N
Swollen Glands	Y	N
Excessive Bleeding	Y	N
Other _____	Y	N

ALLERGIC-IMMUNOLOGIC		
Sinus Allergy Symptoms	Y	N
Frequent Illnesses	Y	N

Reviewed and discussed with patient.

Physician Signature: _____ Date Reviewed: _____