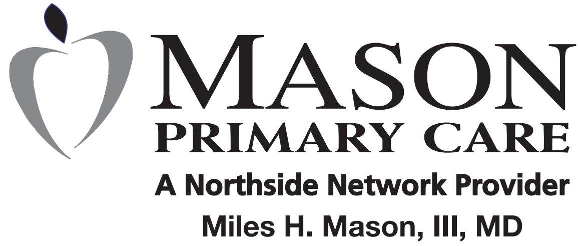

A Northside Network Provider

Miles H. Mason, III, MD

English - Spanish

ECW ID # ______________________________ **Date:** ________________________

Patient Name: ____ **Date of Birth** ___ /___ /_____

REASON FOR VISIT:

____

____

____

____

MEDICATIONS SUPPLEMENTS AND VITAMINS: **(Please list the name, dosage and frequency of current medications)**

	MEDICATION	DOSAGE	FREQUENCY (HOW OFTEN)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

☐ **Patient brought in Medication List** ☐ **Medication List Reviewed by MA**

Allergies: ____

____

PATIENT INTAKE FORM

Patient Name: ________________________________ **Date of Birth** ___ /___ /_____

PAST MEDICAL HISTORY: (Please check box and put date diagnosed)

☐ High Blood Pressure ____________
☐ High Cholesterol ____________
☐ Diabetes ____________
☐ Stroke ____________
☐ Anxiety ____________
☐ Arthritis ____________
☐ Kidney Disease ____________
☐ Asthmas ____________
☐ Osteoporosis ____________
☐ Depression ____________
☐ Thyroid Disease (please specify) ____________
☐ Heart Disease (please specify) ____________
☐ Cancer (please specify) ____________
☐ Clotting disorder (please specify) ____________
☐ Acid Reflux ____________
☐ Other: ________________________________

PAST SURGICAL HISTORY: (Please list any surgical procedures, hospitalizations and their dates)

NAME	DATE

SOCIAL HISTORY

Do you currently smoke or chew tobacco? ☐ Yes ☐ No
If yes, how long have you smoked? ____________
How much do you smoke per day? ____________
Do you currently drink alcohol? ☐ Yes ☐ No
How much do you drink? ____________
Do you feel like you need to cut back? ____________
If you smoked previously, how long did you smoke, how much per day and when did you quit?
____

Do you exercise regularly? ☐ Yes ☐ No If yes, how often and for how long do you exercise? ____________
Have you used illicit drugs? ☐ Yes ☐ No If yes, what have you used? ____________
Do you desire STD Screening? ☐ Yes ☐ No

FAMILY HISTORY (Please list below blood relatives that have a history of the following:)

(☑) boxes that apply	Living	Deceased	Age / Age at Death	Stroke	Hypertension	Kidney Disease	Heart Disease	Diabetes	Cancer	Other (Please list)
Mother										
Father										
Siblings										
Grandmothers										
Grandfathers										
Aunts										
Uncles										
1st Cousins										
Children										

Patient Name: ______________________________ **Date of Birth** ___ /___ /_____

PLEASE FILL IN DATE OF YOUR LAST:

Colonoscopy		Pap Smear		Shingles shot	
Mammogram		Flu shot (Regular/High Dose)		Pneumonia shot (Pneumovax 23)	
Bone Density		Tetanus shot		Pneumonia shot (Prevnar 13)	
First day of last menstrual cycle:					

REVIEW OF SYSTEMS (Please verify if you have had any of the following within the last 30 days)

Please circle all that apply and explain

CONSTITUTIONAL

Fever YES NO ____________
Weight Loss YES NO ____________
Difficulty Sleeping YES NO ____________
Fatigue YES NO ____________
Weight Gain YES NO ____________
Dehydration YES NO ____________
Headache YES NO ____________

EYES

Changes in Vision YES NO ____________
Far-Sightedness YES NO ____________
Near-Sightedness YES NO ____________
Total Vision Loss YES NO ____________
Eye Pain YES NO ____________

EARS, NOSE, MOUTH, AND THROAT

Loss of Hearing YES NO ____________
Cold Symptoms YES NO ____________
Ringing in Ears YES NO ____________
Hoarseness YES NO ____________
Sneezing Spells YES NO ____________
X-Ray Exposure to Tonsils, Adenoids, Thymus, or Face YES NO ____________

BREASTS

Lumps YES NO ____________
Nipple Discharge YES NO ____________
Tenderness YES NO ____________
Abnormal Changes in Breast Size YES NO ____________

RESPIRATORY

Wheezing YES NO ____________
Dry Cough YES NO ____________
Shortness of Breath YES NO ____________
Productive Cough YES NO ____________

CARDIOVASCULAR

High Blood Pressure YES NO ____________
Heart Trouble YES NO ____________
Palpitations YES NO ____________
Edema (swelling) YES NO ____________
Chest Pain YES NO ____________

GASTRONINTESTINAL

Abdominal Pain YES NO ____________
Vomiting YES NO ____________
Nausea YES NO ____________
Blood in Stool YES NO ____________
Tarry or Black Stool YES NO ____________
Hemorrhoids YES NO ____________
Hernias YES NO ____________
Heartburn YES NO ____________
Diarrhea/Loose Stools YES NO ____________
Mucus in Stool YES NO ____________
Loss of Appetite YES NO ____________
Bloating YES NO ____________
Constipation YES NO ____________
Excessive Belching YES NO ____________
Changes in Bowel Habits YES NO ____________

GENITOURINARY

Difficulty Urinating YES NO ____________
Sexually Transmitted Infections YES NO ____________
Incontinence YES NO ____________
Kidney Trouble YES NO ____________
Irregular Periods YES NO ____________
Erectile Dysfunction YES NO ____________

NEUROLOGIC

Dizziness YES NO ____________
Fainting YES NO ____________
Muscular Weakness YES NO ____________
Tingling or Numbness YES NO ____________
Seizures YES NO ____________
Nervous Disorders YES NO ____________

MUSCULOSKELETAL

Joint Pain YES NO ____________
Joint Swelling YES NO ____________
Reddish Coloring at Joints YES NO ____________
Stiffness YES NO ____________
Muscle Pain YES NO ____________
Muscular Weakness YES NO ____________
Back Pain YES NO ____________
Arm Pain YES NO ____________
Leg Pain YES NO ____________
Leg Cramps YES NO ____________
Urge to Move Legs YES NO ____________

ENDOCRINE

Thyroid Disease YES NO ____________
Diabetes Mellitus YES NO ____________

PSYCHIATRIC

Depressive Symptoms YES NO ____________
Anxiety YES NO ____________
Psychosis YES NO ____________
Hallucinations YES NO ____________

ALLERGIC-IMMUNOLOGIC

Sinus Allergy Symptoms YES NO ____________
Allergic Dermatitis YES NO ____________

Patient's Signature: ______________________________ **Date:** ____________

PATIENT INTAKE FORM