Patient Intake Form

Patient Name: (Last)________________________________(First)______________________________(MI)______________
Patient Address: ____
City:____State:_______________Zip:____________________________
Home Phone:_____________________________________Cell:____
Birthdate:____Age:__________Sex: M F
Country of Birth:___________________________________Country of Parents' Birth: _________________________
How did you hear about us?____
Marital Status (circle): Single Married Divorced Separated
Employer:__________________________________Years of Employment:___________________________________
____ Insurance Provider:______________________Name of Policy
Holder:____________________________________D.O.B.______________________________ Insurance Member #______
____Group #____________________________________ Email:___________
____Social Security:______________________-_______-____________

In Case of Emergency:

Name:_____________________________________Relationship:_______________Phone:_____________________
Patient's Spouse:____Phone:_____________________
Family Physician:____Phone:_____________________
Referred by: ____

Relative Medical History

Do you have changes in your memory?____
Have you experienced a loss of interest in normal daily activities?___________________________________
____
Have you noticed a change in normal cognitive brain function?_______________________________________
Do you struggle with recalling certain words?____
Do you ever forget where you place your keys, phone, or wallet/purse?________________________________
____ Do you have a hard time following instructions?____
____ Do you ever get lost in familiar places?____
Do you ever ask the same questions over and over again?____

Sexual Function History:

Suffer from low sex drive:___________If Yes, how long?____
Low energy:________If yes, what time of day?____________________________How long?_________________
Males: Erectile Dysfunction:______________Premature Ejaculation:_________________Soft Erections:______________
Females: Vaginal Dryness:______________Difficulty Reaching Orgasm:________________Painful Sex:______________
Your present weight:_your weight goal:____________________________________height:_ What was your highest weight? (excluding pregnancy)_______your age then__________________________# of years ago:_____________
What was your lowest weight?________________your age then________________# of years ago:_____________
Have you ever stayed the same weight for 10 years or more? Yes / No
Have you attempted to lose weight before?_______most lbs lost:________________how long it took:_____________
Describe previous methods of weight loss (e.g. diets, pills, injections, hypnosis, acupuncture) and describe your results:____
Do you currently have any medical concerns? Please List:____

Do you currently smoke?________________If Yes, what do you smoke? (cigarettes/vaping)____________________

If yes, how much per day?(how many cigarettes/packs per day)___________________

If you've quit, when?______________
Do you drink alcohol?____________If yes how many drinks in a day?_____________

How often do you drink alcohol? (how many times a week or a month)____________________________________

Drug Use: (Please check if you have used any of the following):

☐ Marijuana
☐ Cocaine/Crack
☐ MDMA/Ecstasy
☐ Amphetamines/speed
☐ Methamphetamine
☐ Heroin
☐ Barbituates
☐ Non-prescription Opioids
☐ Other ________________________________

How much water do you drink in a day? (not including coffee, tea,soda,etc)_________________________________
What else do you drink besides water? ____ Do you exercise?_______________If Yes, how many times a week?______________For how long?________________
What do you do for exercise? ____

Past History: (Please check if you have had any of the following):

☐ Allergies, Type:____________________
☐ Birth defects or abnormalities
☐ Exposed to tuberculosis
☐ Measles
☐ Unexplained weight loss
☐ Unexplained fever
☐ Frequent Colds
☐ Unexplained pain
☐ Recent pneumonia
☐ Diabetes: Type: ______________________________________
☐ Cancer, Type:___________________________
☐ Other Diseases ____
☐ Operations: (dates) ____

Current Medications (vitamins, birth control pills): ____
Any mood altering or depression medication:____
Allergies to medicines, foods, etc____

Family History:

Father: Health______________Age_______Deceased______at age______Cause____________________________
Mother: Health______________Age_______Deceased______at age______Cause ___________________________
# of siblings:_______# living_______ #deceased:_________Cause ____

Family Diseases: Check diseases known in your blood relatives (not yourself)

☐ High blood pressure
☐ Allergy
☐ Heart trouble
☐ Anemia
☐ Migraine
☐ Bleeding (abnormal)
☐ Dropsy
☐ Epilepsy
☐ Strokes
☐ Cancer
☐ Diabetes
☐ Nervous breakdown
☐ Kidney disease
☐ Syphilis or (bad blood)
☐ Suicide
☐ Obesity
☐ Arthritis
☐ Rheumatic
☐ Fever
☐ Other ____

Examinations:

Date of last physical examination_______________Reason:____
Hospitalizations__________Dates_____________Reason:____
X-Rays: Chest_________Stomach_____________ Gallbladder_________Kidney______________Colon________
Other___________________________________Date of last laboratory tests:_____________________________
Electrocardiogram (heart tracing)_____________Date of last colonoscopy:____________________ Date of last pap (Females): ________________________________
Date of last PSA (Males): _____________________________

Do you now have or have had any of the following?

☐ Itching ☐ Eczema ☐ Hives ☐ Joint pains ☐ Muscle aches
☐ Arthritis ☐ Limitation of motion ☐ Backache ☐ Leg pains ☐ Heel Pains
☐ Neck Pain ☐ Numbness ☐ Goiter ☐ Swollen, enlarged glands
☐ Asthma ☐ Lung disease ☐ Blood Clots ☐ Emphysema ☐ Hemorrhoids
☐ Heart trouble ☐ Tire easily ☐ High blood pressure ☐ Shortness of breath ☐ Palpitation
☐ Chest pain ☐ Swelling of ankles ☐ Gas or bloating ☐ Colitis ☐ Hernia
☐ Indigestion ☐ Unexplained nausea ☐ Abdominal pain ☐ Diarrhea
☐ Constipation Number of bowel movements - daily _____
☐ Jaundice ☐ Rectal bleeding or black stools
☐ Kidney disease ☐ Gallbladder disease ☐ Kidney stones
☐ Painful urination ☐ Pus or blood in urine ☐ Albumin or sugar in urine
☐ Dribbling of urine ☐ Varicose veins ☐ Nervousness or anxiety
☐ Trouble sleeping ☐ Headaches ☐ Depression
☐ Fainting ☐ Convulsions ☐ Loss of consciousness
☐ Paralysis

FEMALES ONLY:

Menstrual History:

Menstruation began at age:___________28 day cycle?________If no, how many days? ____________________
Duration of bleeding:_____________________________Pain with periods?_______________________________
Amount of flow : Light____________Med._________________________Heavy____________________
Date of 1st day of last menstrual cycle:____________________________
Bleeding between periods:_________________________Bleeding after intercourse:________________________
Irritation or discharge:____________________________Itching or burning ___________________________________
History of PCOS (polycystic ovarian syndrome): ___________________
Are you on birth control? (method, i.e. IUD, Birth control pills, Condoms, Diaphragm, Tubal ligation):

Consent to Treat:

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.
I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient's Signature ____ Date

Financial Policy:
Thank you for selecting VarioHealth for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements.

Patient's Signature ______________________________ Date

All Statements on this patient intake form are accurate and true to the best of my knowledge. I understand that treatments will be based on the information provided herein. If I willingly withhold knowledge from my treating physician, I accept full liability from any consequences arising there from.

Patient's Signature ______________________________ Date