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Fairfax, Fair Oaks and Loudoun Medical Campus

Patient Intake Form

Patient Name _____ **Visit Date** _____
Phone (home) _____ (work) _____ (cell) _____
E-mail address: _____

May we leave personal messages for you on your **voicemail?** ☐Yes☐No **email?**☐Yes☐No

Marital Status: _____With whom do you live? _____

DOB ____/____/____ **Age**_____

Are you currently employed: ☐ No ☐ Yes ☐ Retired **Occupation**: _____

Referring physician (name and phone number):

_____

Primary Care Physician (name and phone number):

_____

Other physicians you would like us to keep informed (name and phone number):

_____

Reason for visit:

_____

Medical Information:

Height: _____Weight: _____ Recent weight loss? _____pounds _____months

Do you have pain? _____

Do you smoke now? No ☐ Yes ☐ Did you smoke in the past? No ☐ Yes ☐

When did you stop? _____ How many packs per day? _____ How many years? ____

About how much alcohol do you drink? None ☐ Occasionally ☐ 1 drink/day ☐

2-3 drinks/day ☐ More than 3 drinks/day ☐

Have you ever been treated for drug/alcohol addiction? No ☐ Yes ☐

Drug Allergies No ☐ Yes ☐ Please list:

_____
_____
_____

Medication List:

Current Medications:	For the Treatment of:	Dose	How Often?

Major Medical Problems (diabetes, heart, lung, blood pressure, scleroderma, connective tissue disorder):

_____

_____

_____

Prior Surgeries & Dates:

_____

_____

Hospitalizations & Dates:

_____

_____

Previous radiation treatment? No ☐ Yes ☐ When/Where?

_____

Previous or current chemotherapy? No ☐ Yes ☐ When/Where?

_____

_____

History of cancer in the family:

_____

_____

Pharmacy: _____ Phone**:** _____

Do you have an implanted medical device including, but not limited to, pacemakers, defibrillators, neurostimulators, drug infusion pumps or prostheses? No ☐ Yes ☐ please list type, manufacturer and physician contact information:

_____

_____

*We do not release information about you without your consent. If you wish to give us permission to speak freely with certain relatives or friends, please list their names and relationship to you.

_____

_____

Emergency Contact(s): Name, Relation, and Phone Number

_____

_____

Review of Systems

Are you currently experiencing or have you experienced any of the following symptoms **within the last 30 days?**

	Yes	NO
Constitutional		
Appetite change	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Weight Loss	☐	☐
Eyes		
Eye Discharge	☐	☐
Eye Pain	☐	☐
Head/Ears/Nose/Throat		
Hearing loss	☐	☐
Pain in ears	☐	☐
Ringing in ears	☐	☐
Nose bleeds	☐	☐
Congestion	☐	☐
Dental problem	☐	☐
Sore Throat	☐	☐
Trouble swallowing	☐	☐
Voice change	☐	☐
Respiratory		
Chronic cough	☐	☐
Difficulty breathing	☐	☐
Wheezing		
Cardiovascular		
Chest pain	☐	☐
Leg Swelling	☐	☐
Palpitations	☐	☐
Pacemaker	☐	☐
Gastrointestinal		
Abdominal pain	☐	☐
Blood in stools	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Genitourinary		
Difficulty urinating	☐	☐
Burning upon urination	☐	☐
Frequent urination	☐	☐
Blood in urine	☐	☐
Urgency	☐	☐
Sexual activity	☐	☐

	Yes	NO
Reproductive-Female		
Breast lumps	☐	☐
Nipple discharge	☐	☐
Estrogen Replacement (current or previous) – Years _____	☐	☐
Last menstrual period /		
Age when periods began		
Number of pregnancies:		
Number of live births:		
Age at 1st birth:		
Musculoskeletal		
Joint Pain/arthritis	☐	☐
Back Pain	☐	☐
Problems walking	☐	☐
Joint Swelling	☐	☐
Skin		
Rash	☐	☐
Wound	☐	☐
Neurologic		
Dizziness	☐	☐
Headaches	☐	☐
Numbness	☐	☐
Seizures	☐	☐
Speech difficulty	☐	☐
Fainting	☐	☐
Weakness in arms or legs	☐	☐
Hematologic		
Swollen lymph nodes	☐	☐
Bruises/Bleed easily	☐	☐
Immunology		
Rheumatoid arthritis	☐	☐
Lupus	☐	☐
Scleroderma	☐	☐
Psychiatric		
Agitation	☐	☐
Confusion	☐	☐
Depressed mood	☐	☐
Nervous/Anxiety	☐	☐