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HMA
huguley medical associates

## INTAKE HISTORY

**NAME:** _____ **BIRTH DATE:** _____ **DATE:** _____

**ADDRESS:** _____

**CITY** _____ **STATE/ZIP:** _____

**HOME TEL:** ( ) _____ **WORK TEL:** ( ) _____

**EMPLOYER:** _____ **INSURANCE:** _____

**NAME OF SPOUSE/ PARTNER:** _____ **REFERRED BY** _____

## PERSONAL PAST HISTORY

| MAJOR ILLNESSES | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Asthma | | | Cancer | | |
| Thyroid Disease | | | Ulcers | | |
| High Blood Pressure | | | Depression/anxiety | | |
| Kidney Infections/stones | | | Anemia/Blood transfusions | | |
| Blood Clots/Pulm. Embolism/DVT | | | Seizures/convulsions/epilepsy | | |
| Heart attack/myocardial infarction | | | Bowel trouble/constipation/diarrhea | | |
| Heart Disease/murmur | | | High Cholesterol/Lipid disorder | | |
| Diabetes | | | Arthritis/joint pain | | |
| COPD/Emphysema/Lung disease | | | HIV/AIDS | | |
| Stroke | | | Hepatitis B or C | | |
| Rheumatic Fever | | | Other Illnesses | | |

## PAST SURGERIES/HOSPITALIZATIONS/ILLNESSES/INJURIES

| Procedure/Reason | Month/Year | Procedure/Reason | Month/Year |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## OBSTETRIC HISTORY

| | |
|---|---|
| Vaginal Births: C-Sections: | Abortions |
| Miscarriages | Living children |

## GYNECOLOGIC HISTORY

LAST MENSTRUAL PERIOD: / / NORMAL: Y N DURATION OF FLOW: DAYS FREQUENCY:
AGE OF FIRST PERIOD:
LAST PAP SMEAR: / / NORMAL: Y N HISTORY OF ABNORMAL PAP'S:
SEXUALLY ACTIVE: Y N NUMBER OF LIFETIME PARTNERS: AGE OF CURRENT PARTNER:
HISTORY OF SEXUALLY TRANSMITTED INFECTIONS (HIV, SYPHILIS, GENITAL HERPES, GENITAL WARTS, HEPATITIS B OR C, TRICHOMONIASIS)
Y N IF YES, WHICH:_____
IF YES, LAST TIME OF INFECTION/OUTBREAK:

## CURRENT MEDICATIONS

| Drug Name | Dosage | Drug Name | Dosage |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

DRUG ALLERGIES: NO YES WHICH?_____

## FAMILY HISTORY

| Illness | Yes | Relative | Illness | Yes | Relative |
|---|---|---|---|---|---|
| Diabetes | | | Drinking Problem | | |
| Stroke | | | Breast Cancer | | |
| Heart Disease | | | Colon Cancer | | |
| High Blood Pressure | | | Ovary, Cervix, other Cancer | | |

## SOCIAL HISTORY

Habits

| | | | | |
|---|---|---|---|---|
| Smoking | Yes ☐ | No ☐ | Packs per day_____ | Years_____ |
| Alcohol | Yes ☐ | No ☐ | Drinks per day_____ | Drinks per week_____ |
| Drug Use | Yes ☐ | No ☐ | | |
| Seat Belt Use | Yes ☐ | No ☐ | | |
| Regular Exercise | Yes ☐ | No ☐ | | |

Personal Profile

Marital Status Married ☐ Single ☐ Widowed ☐ Divorced ☐
Number of Living Children_____
Number of people in household_____
School Completed High School ☐ College ☐ Graduate Degree ☐ Other ☐
Current or most recent job_____

## REVIEW OF SYSTEMS

**PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST OR OFTEN**

| **1. CONSTITUTIONAL** | **Yes** | **No** | **Occasional** | **NOTES** |
|---|---|---|---|---|
| **Weight loss** | ☐ | ☐ | ☐ | |
| **Weight gain** | ☐ | ☐ | ☐ | |
| **Fever** | ☐ | ☐ | ☐ | |
| **Fatigue** | ☐ | ☐ | ☐ | |
| **2. EYES** | | | | |
| **Double vision** | ☐ | ☐ | ☐ | |
| **Spots before eyes** | ☐ | ☐ | ☐ | |
| **Vision changes** | ☐ | ☐ | ☐ | |
| **3. ENT/MOUTH** | | | | |
| **Ear aches** | ☐ | ☐ | ☐ | |
| **Ringing in ears** | ☐ | ☐ | ☐ | |
| **Sinus problems** | ☐ | ☐ | ☐ | |
| **Sore throat** | ☐ | ☐ | ☐ | |
| **Mouth sores** | ☐ | ☐ | ☐ | |
| **Dental problems** | ☐ | ☐ | ☐ | |
| **4. CARDIOVASCULAR** | | | | |
| **Painful breathing** | ☐ | ☐ | ☐ | |
| **Chest pain** | ☐ | ☐ | ☐ | |
| **Difficult breathing on exertion** | ☐ | ☐ | ☐ | |
| **Swelling of legs** | ☐ | ☐ | ☐ | |
| **Palpitations of heart** | ☐ | ☐ | ☐ | |
| **5. RESPIRATORY** | | | | |
| **Wheezing** | ☐ | ☐ | ☐ | |
| **Spitting up blood** | ☐ | ☐ | ☐ | |
| **Shortness of breath** | ☐ | ☐ | ☐ | |
| **Cough, chronic** | ☐ | ☐ | ☐ | |

**PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST OR OFTEN**

| GASTROINTESTINAL | YES | NO | OCCASIONAL | NOTES |
|---|---|---|---|---|
| Diarrhea, frequent | ☐ | ☐ | ☐ | |
| Bloody stool | ☐ | ☐ | ☐ | |
| Nausea/vomiting | ☐ | ☐ | ☐ | |
| Constipation | ☐ | ☐ | ☐ | |
| **6. GENITOURINARY** | | | | |
| Blood in urine | ☐ | ☐ | ☐ | |
| Pain with urination | ☐ | ☐ | ☐ | |
| Urgency | ☐ | ☐ | ☐ | |
| Frequency of urination | ☐ | ☐ | ☐ | |
| Incomplete emptying | ☐ | ☐ | ☐ | |
| Stress incontinence | ☐ | ☐ | ☐ | |
| Abnormal periods | ☐ | ☐ | ☐ | |
| Painful intercourse | ☐ | ☐ | ☐ | |
| **8. MUSCULOSKELETAL** | | | | |
| Muscle weakness | ☐ | ☐ | ☐ | |
| Joint Aches/Pains | ☐ | ☐ | ☐ | |
| **9. SKIN/BREAST** | | | | |
| Pain in breast | ☐ | ☐ | ☐ | |
| Discharge | ☐ | ☐ | ☐ | |
| Masses | ☐ | ☐ | ☐ | |
| Rash | ☐ | ☐ | ☐ | |
| Ulcers | ☐ | ☐ | ☐ | |
| **10. NEUROLOGICAL** | | | | |
| Dizziness | ☐ | ☐ | ☐ | |
| Seizures | ☐ | ☐ | ☐ | |
| Numbness | ☐ | ☐ | ☐ | |
| Trouble walking | ☐ | ☐ | ☐ | |
| **11. PSYCHIATRIC** | | | | |
| Depression | ☐ | ☐ | ☐ | |
| Crying, frequent | ☐ | ☐ | ☐ | |
| **12. ENDOCRINE** | | | | |
| Dry skin | ☐ | ☐ | ☐ | |
| Abnormal thirst | ☐ | ☐ | ☐ | |
| Hot flashes | ☐ | ☐ | ☐ | |
| **13. HEMATOLOGIC/LYMPHATIC** | | | | |
| Bruises, frequent | ☐ | ☐ | ☐ | |
| Cuts do not stop bleeding | ☐ | ☐ | ☐ | |
| Enlarged lymph nodes | ☐ | ☐ | ☐ | |
| **14. ALLERGIC/IMMUNOLOGIC** | | | | |
| Allergies | ☐ | ☐ | ☐ | |
| Drugs, other | ☐ | ☐ | ☐ | |

Completed by: Patient ☐ Office Nurse ☐ Physician ☐

Signature of patient: _____

Date reviewed by physician with patient: _____

Physician Signature: _____

Annual Review of History

Date reviewed: _____ Physician Signature: _____

Date reviewed: _____ Physician Signature: _____

Date reviewed: _____ Physician Signature: _____

Date reviewed: _____ Physician Signature: _____