National Jewish Health

NATIONAL JEWISH SOUTH DENVER
ESTABLISHED PATIENT INTAKE FORM

NAME:________________________ Birthdate:____________ Date:______________

Primary Physician:____

Other Physicians (to send information to):______________________________

GENERAL NONE
Y N Fevers
Y N Night sweats
Y N Fatigue- chronic
Y N Appetite loss
Y N Weight Loss- unintentional
Y N Weight Gain- >20lbs/6m.

RESPIRATORY NONE
Y N Cough- dry
Y N Cough- with phlegm
Y N Cough- with blood

Shortness of breath:
Y N -- At rest
Y N -- With activity

Y N Wheezing
Y N Chest tightness
Y N Frequent Bronchitis
Y N Pleurisy

Y N Oxygen use?
_____L/M Rest
_____L/M Exercise
_____L/M Nights

SLEEP NONE
Y N Morning headaches
Y N Excessive daytime sleepiness
Y N Excessive snoring
Y N Restless sleep
Y N Nocturnal Awakenings
Y N Sleep disturbance secondary to breathing
Y N CPAP/BiPAP use

CPAP setting: ____________

hours using nightly ______

NASAL/Throat NONE
Y N Nasal congestion
Y N Postnasal drip
Y N Seasonal allergies
Y N Sinus disease
Y N Voice hoarseness
Y N Vocal Cord Abnormality

ENDOCRINE NONE
Y N Thyroid problems
Y N Diabetes

CARDIAC NONE
Y N Heart Attack (MI)
Y N Heart Murmur
Y N Chest Pain with Activity
Y N Increasing leg edema
Y N Palpitations
Y N Atrial Fibrillation / SVT
Y N Pacemaker?
Y N Defibrillator (ICD) ?
Y N Leg Pains with walking
Y N Passing out/Syncope

ABDOMINAL: NONE
Y N Heartburn/reflux/GERD
Y N Trouble Swallowing
Y N Choking spells
Y N Abdominal pain
Y N Nausea/Vomiting
Y N Hepatitis or Jaundice

MUSCULOSKELETAL: NONE
Y N Osteoarthritis/ DJD
Y N Osteopenia/Osteoporosis
Y N Rash/Skin lesions
Y N Gout
Y N Back/Disc Pain.
Y N Trouble walking
Y N Bone Pain

GENITOURINARY NONE
Y N Frequent Urination
Y N Blood in urine
Y N Frequent infections
Y N Enlarged Prostate

GYNECOLOGICAL NONE
Y N Are you presently or could you be pregnant
Y N Post-Menopausal
Y N Abnormal Mammogram

BLOOD/ HEME NONE
Y N Anemia
Y N Blood clots- Legs (DVT)

Y N Blood Clots- Lungs (PE)
Y N Impaired Immune System
Y N Low Platelets
Y N Unusual Bleeding

NEUROLOGICAL NONE
Y N Fainting Spells
Y N Balance Problems
Y N Tremors
Y N Dizziness
Y N Seizures
Y N Mini strokes/TIA/stroke
Y N Headaches/Migraines
Y N Muscle Weakness
Y N Memory Problems
Y N Difficulty Swallowing

EYES NONE
Y N Glaucoma/ Cataracts
Y N Dry Eyes- recurrently
Y N Conjunctivitis/Uveitis

MENTAL HEALTH: NONE
Y N Anxiety
Y N Depression
Y N Suicidal thoughts
Y N Sleeping difficulty
Y N Claustrophobia

HEALTH MAINTENANCE:
PNEUMONIA VACCINE
Date______within the last 5 years

FLU VACCINE
Date________this year

Y N ADVANCED Directives

SMOKING HISTORY How much?
Y N PAST
Y N PRESENT
Y N NEVER

Any new medical problems since your last visit?

____

____

Have you been hospitalized since your last visit? If yes, where?

____

____

____

____

SOD 020 (11/17)

Preferred Retail Pharmacy ______________________________

Address ______________________________

Phone # ______________ **Fax #** ______________

Preferred Mail Order Pharmacy ______________________________

Address ______________________________

Phone # ______________ **Fax #** ______________

Preferred Laboratory (circle one) **Quest** **LabCorp** **Any**

What company provides your Oxygen/CPAP supplies? ______________________________