

DEBORA CHELSON, N.M.D.
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Patient Intake Form

NAME _____ DATE _____ DOB _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE _____ OCCUPATION _____ EMPLOYER _____ WK PHONE _____

MARITAL STATUS _____ CHILDREN / AGES _____ LAST DR. VISIT / WHY _____

REASON FOR TODAY'S VISIT _____ HOW REFERRED HERE _____

SERIOUS ILLNESS OR ACCIDENTS YOU'VE HAD _____

REACTION TO DRUGS OR VACCINATIONS _____ ALLERGIES _____

CURRENT HEALTH CONDITIONS OR CONCERNS YOU HAVE _____

CURRENT MEDICATIONS YOU ARE TAKING _____

DO YOU SMOKE ____ (IN PAST) ____ HOW LONG _____ HOW MANY _____ DRINK COFFEE TEA SODA _____

USE RECREATIONAL DRUGS _____ DRINK ALCOHOL _____ DAILY _____ AMOUNT _____

DO YOU EXERCISE _____ WHAT FORM / HOW OFTEN _____

ARE YOU SATISFIED WITH YOUR CURRENT STATE OF HEALTH _____

DO YOU ENJOY YOUR JOB / WORK _____

HOW IS YOUR FAMILY / HOME LIFE _____

WHAT ISN'T WORKING IN YOUR LIFE _____

DO YOU HAVE AN ACTIVE SPIRITUAL OR RELIGIOUS LIFE _____

WHAT WOULD YOU CHANGE IN YOUR HEALTH / LIFE _____

ARE YOU SEXUALLY ACTIVE _____ IF SO, ARE YOU SATISFIED _____ IF NOT, WHY _____

WHAT WOULD YOU LIKE TO CHANGE IN YOUR HEALTH / LIFE _____

FAMILY HISTORY – HAS ANYONE IN YOUR FAMILY HAD :

ASTHMA _____ BLOOD DISORDERS _____ HEADACHES _____ SKIN DISEASE _____
ARTHROSIS _____ CANCER _____ HEART DISEASE _____ STROKE _____
ALLERGIES _____ DEPRESSION _____ HIGH BLOOD PRESSURE _____ WEIGHT PROBLEM _____
ALCOHOLISM _____ DIABETES _____ STOMACH / BOWEL DISORDER _____

RELATIVE: HEALTH STATUS: AGE: IF DECEASED, AGE WHEN IT OCCURRED & CAUSE

FATHER _____

MOTHER _____

SIBLINGS _____

MEN: DATE OF LAST PROSTATE EXAM _____ DATE OF LAST PSA LAB TEST _____

WOMEN: NUMBER OF PREGNANCIES _____ BIRTHS _____ MISCARRIAGES _____ INDUCED ABORTIONS _____

FIRST DAY OF LAST PERIOD _____ LAST PAP _____ BIRTH CONTROL IN PAST _____ AT PRESENT _____

LENGTH OF CYCLE / FLOW _____ DAYS ANY COMPLAINTS _____

HOT FLASHIES _____ INSOMNIA _____ MOOD SWINGS _____ DECREASED ENERGY _____ DECREASED LIBIDO _____

PERSONAL HISTORY – CURRENTLY OR IN PAST HAVE YOU EXPERIENCED ANY OF THE FOLLOWING :

ABUSE ___ ALLERGIES ___ ARTHRITIS ___ PHYSICAL TRAUMA ___ HEADACHE / RECURRING ___ STOMACH / BOWEL DISORDERS ___

VENEREAL DISEASE ___ HEART DISEASE ___ HEPATITIS ___ ASTHMA ___ THYROID DISEASE ___ HIGH BLOOD PRESSURE ___

CHRONIC CONSTIPATION / DIARRHEA ___ SHORT OF BREATH ___ HERPES ___ DEPRESSION ___ SKIN DISEASE ___

CANCER ___ AIDS ___ MOST RECENT HIV TEST ___ HPV (GENITAL WARTS) ___ OTHER _____

EMERGENCY CONTACT _____ PHONE _____

PLEASE READ AND SIGN: I understand that payment for services, lab and pharmacy items are due in full at the time i receive them. There will be a \$50.00 fee charged for missed appointments or appointments cancelled with less than 24 hours notice.

Patient Signature

Date

ALSO – Please provide your email address so we can send information and forms to you in the future. Thank you !

Patient Email Address