DEBORA CHELSON, N.M.D.

5102 S. Thunder Sky Way, Tucson, AZ 85747 ❖ (520) 437-9562

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 _____

ARTHRITIS _____ 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