Empower Rheumatology LLC.

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Medical Intake Form

1. Please enter your information.

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Gender:
○ Female ○ Male

Marital Status:
○ Single ○ Married ○ Domestic Partner
○ Separated ○ Divorced ○ Widowed

Address: _____ Apt./Unit #: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone
○ Email

Social Security Number _____

2. Preferred Language:

○ English ○ Spanish ○ Other

If other, please specify: _____

3. Race (Please check all that apply):

☐ White ☐ Black ☐ Asian
☐ American Indian/Native Alaskan ☐ Native Hawaiian/Pacific Islander ☐ Other

If other, please specify: _____

4. Ethnicity:

☐ Hispanic/Latino(a)

5. **Please list individuals (and relationship) with whom you allow us to share your health information:**

	Name	Relationship
1		
2		
3		

6. **Do you have Medical Insurance?**

○ Yes ○ No

7. **Primary Insurance:**

Primary Insurance Company:

Group #: Policy/ID #:

Subscriber Name: Relationship: Date of Birth:

8. **Secondary Insurance:**

Secondary Insurance Company:

Group #: Policy/ID #:

Subscriber Name: Relationship: Date of Birth:

9. **I authorize the release of any medical information necessary to process my claim and payment of benefits.**

Authorization

Signature Date

What brings you in today?

10. **Problem 1:**

Please describe the issue you're experiencing:

How long have you had this problem?

How severe is this problem?
○ Mild ○ Moderate ○ Severe

Have you tried anything to treat this problem?

11. **Problem 2:**

Please describe the issue you're experiencing:

How long have you had this problem?

How severe is this problem?
○ Mild ○ Moderate ○ Severe

Have you tried anything to treat this problem?

12. **Problem 3:**

Please describe the issue you're experiencing:

How long have you had this problem?

How severe is this problem?
○ Mild ○ Moderate ○ Severe

Have you tried anything to treat this problem?

13. **How would you rate your health?**

○ Excellent ○ Good ○ Fair
○ Poor

14. **What goal(s) do you have for your health this year?**

15. **What are some of the things you do that bring you joy?**

Review of Systems

Do you have any problems with the following? Please check the correct box:

16. **Constitutional**

☐ Lethargy ☐ Fevers/Chills ☐ Unexplained weight loss
☐ Unexplained weight gain ☐ Night Sweats ☐ Fatigue

17. Neurological:

- ☐ Confusion
- ☐ Dizzy/Lightheaded
- ☐ Headaches
- ☐ Memory problems
- ☐ Numbness
- ☐ Loss of balance
- ☐ Burning in Extremities
- ☐ Tremors
- ☐ Syncope(passing out)

18. Eyes:

- ☐ Blurry/Double Vision
- ☐ Burning
- ☐ Redness
- ☐ Loss of Vision
- ☐ Dryness
- ☐ Pain
- ☐ Tearing

19. Ear/Nose/Throat:

- ☐ Congestion
- ☐ Ear Pain
- ☐ Facial pain/numbness
- ☐ Hoarseness
- ☐ Nose bleeds
- ☐ Sinus pain
- ☐ Ringing in the Ears
- ☐ Mouth or Nose sores
- ☐ Dry mouth
- ☐ Loss of smell
- ☐ Jaw pain
- ☐ Loss of hearing
- ☐ Bad taste in Mouth
- ☐ Sore Throat
- ☐ Loss of Appetite

20. Respiratory:

- ☐ Blood in Sputum
- ☐ Persistent Coughing
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Wheezing

21. Cardiovascular:

- ☐ Angina/Chest Pain
- ☐ Ankle Swelling
- ☐ Exercise Intolerance
- ☐ Heart Palpitation
- ☐ Leg Pain with Walking
- ☐ Shortness of Breath
- ☐ Murmur
- ☐ High Blood Pressure

22. Gastrointestinal:

- ☐ Abdominal Pain
- ☐ Blood in Stool
- ☐ Black Stool
- ☐ Bloating
- ☐ Constipation
- ☐ Diarrhea
- ☐ Food Intolerance/Sensitivity
- ☐ Heartburn
- ☐ Nausea/Vomiting
- ☐ Stool Incontinence
- ☐ Change in Bowel Habits
- ☐ Trouble Swallowing
- ☐ Stomach Pain or Cramps

23. Genitourinary:

- ☐ Blood in urine
- ☐ Nighttime urination
- ☐ Heavy/Painful Menses
- ☐ Infertility
- ☐ Impotence
- ☐ Prostate Problems
- ☐ Urine Incontinence
- ☐ Burning with Urination

24. Allergy/Immunology:

- ☐ Frequent Infections
- ☐ Past Anaphylaxis
- ☐ Seasonal Allergies
- ☐ Swollen Glands

25. Hematology:

- ☐ Bleed/Bruise Easily
- ☐ Blood Clots
- ☐ Past Blood Transfusion
- ☐ Enlarged Lymph Gland
- ☐ Anemia

26. Musculoskeletal:

- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Pain
- ☐ Joint Stiffness
- ☐ Pain when Walking, relieved by rest
- ☐ Loss of range of motion
- ☐ Muscle Cramps
- ☐ Fractures
- ☐ Morning Stiffness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Height loss
- ☐ Decreased strength

If joint pain present, how long does it last (in minutes)?

_____

27. Skin/Breast:

- ☐ Breast Lump
- ☐ Skin Rash
- ☐ Hair loss
- ☐ Fingers or toes turning blue
- ☐ Psoriasis
- ☐ Dry Skin
- ☐ Sun Sensitivity
- ☐ Nail Changes
- ☐ Dandruff
- ☐ Scalp Tenderness
- ☐ Itching
- ☐ Boils in Underarm, Groin areas

28. Psychiatric:

- ☐ Anxiety
- ☐ Depression
- ☐ Disordered Eating
- ☐ Poor Sleep
- ☐ Irritability
- ☐ ADHD
- ☐ Problems with Social Activities
- ☐ Problems with Thinking

29. Endocrine:

- ☐ Thirsty
- ☐ Gout
- ☐ Uncontrolled hunger
- ☐ Face shape Change
- ☐ High blood sugar

30. Do you have now (or have you ever had):

Anxiety	No	Past	Yes
Asthma/Emphysema	No	Past	Yes
Arthritis	No	Past	Yes

Blood Clots	No	Past	Yes
Bowel disease	No	Past	Yes
Chronic Pain	No	Past	Yes
Depression	No	Past	Yes
Diabetes Type I	No	Past	yes
Diabetes Type II	No	Past	Yes
Iritis/Scleritis	No	Past	Yes
Heart Attack/Angina	No	Past	Yes
Heart Disease	No	Past	Yes
High Cholesterol	No	Past	Yes
High Blood Pressure	No	Past	Yes
Kidney Disease	No	Past	Yes
Kidney Stones	No	Past	Yes
Liver Disease	No	Past	Yes
Migraines	No	Past	Yes
Neurologic Disorder	No	Past	Yes
Osteoporosis	No	Past	Yes
Recurrent Infections	No	Past	Yes
Seizures/Epilepsy	No	Past	Yes
Stroke/TIA	No	Past	Yes
Thyroid Problems	No	Past	Yes
Immune or autoimmune	No	Past	Yes
TB	No	Past	Yes
Fractures	No	(location)	Yes
HIV/AIDS	No	Past	Yes
Shingles	No	Past	Yes
Stomach Ulcer	No	Past	Yes
Rheumatic Fever	No	Past	Yes
Psoriasis	No	Past	Yes
Pneumonia	No	Past	Yes
Hepatitis	No	Past	Yes
Cancer	No	(type)	Yes

31.

	Yes	No	Past	Location/Type
Cancer	Yes	No	Past	
Implanted Device	Yes	No	Past	
Radiation	Yes	No	Past	
Other	Yes	No	Past	

32. If YES to any of the above(for questions #29 and #30), please explain:

_____

_____

_____

_____

Surgical History

33. Surgery?

○ Yes ○ No

34. Please list your previous surgeries:

	Operation	Month/Year
1. Angioplasty		
2. Appendectomy		
3. Back Surgery		
4. Coronary Artery Bypass		
5. Carpal Tunnel Release		
6. Cholecystectomy		
7. Cataracts		
8. Colostomy		
9. Gastric Bypass		
10. Hernia Repair		
11. Hip Replacement (Right/Left)		
12. Knee Replacement(Right/Left)		
13. Liver Biopsy		
14. Open Reduction Internal Fixation (for fracture repair)		
15. Pacemaker		
16. Small Bowel Resections		
17. Thyroidectomy		
18. Tonsillectomy		
Females Only		
C-section		
Hysterectomy		
Masectomy		
Breast Biopsy		

35. Medications:(if filling out on paper form, please include additional sheet if needed)

	Medication Name	Dosage	Frequency	Reason for taking
1				
2				
3				

36. Please Attach Your Medication List here(if applicable).

37. Blood thinning medications?

○ Yes ○ No

Name of Medication:

_____

38. Recent antibiotic use?

○ Yes ○ No

Name of Antibiotic:

_____

39. Allergies?

○ Yes ○ No Known Allergy ○ Penicillin
○ Sulfa ○ Iodine

40. If yes, please list including reaction:

	Allergy	Reaction
1		
2		
3		

41. Shellfish/Iodine/IV contrast?

○ Yes ○ No

If yes, reaction:

_____

42. Latex?

○ Yes ○ No

43. FEMALES:

Date of Last menstrual period: _____

Age at first period: _____

Are you on contraceptives?
○ Yes ○ No

If yes, please name: _____

Menopause? _____

Hysterectomy? _____

Ovaries removed? _____

Hormone replacement?
○ Yes ○ No

List:

# of Pregnancies:

# of C-Sections:

# of Vaginal:

# of Abortions:

# of Miscarriages:

Pregnancy Complications:
○ Yes ○ No

If yes, please explain:

Date of last pap smear:

Abnormal pap smear(s)?
○ Yes ○ No

Date of last mammogram:

Abnormal?
○ Yes ○ No

44. MALES:

Vasectomy?
○ Yes ○ No

Impotence?
○ Yes ○ No

Erectile Dysfunction?
○ Yes ○ No

Weak urine stream?
○ Yes ○ No

Last PSA result:

Prostate Exam:

Health

45. Do you:

Smoke?
○ Yes (Please specify if cigarettes, cigar, pipe, chewing, snuff and/or electronic smoke) ○ No ○ Past

If past, date quit:

Packs/Day:

Years:

Drink alcohol?
○ Yes (Please specify if daily, weekly, monthly, occasionally or rarely) ○ No ○ Past

If past, date quit:

Have you ever felt a need to cut down on your drinking?
○ Yes ○ No

46. Drink caffeine?

○ Yes ○ No ○ Past

47. Type(s) and cup/s a day:

☐ Coffee: ☐ Tea: ☐ Soda/Pop:

☐ Other:

48. Dietary Restrictions:

_____

49. Use pain medications daily?

○ Yes ○ No ○ Past

Medication name:

_____

50. Use recreational drugs?

○ Yes ○ No ○ Past

51. Please list:

_____

52. Are you Physically Active > 30 min/day:

○ Yes ○ No

53. If yes, how many times per week:

○ 5 or more times per week ○ 3-4 times per week ○ 1-2 times per week
○ Less than 1 time per week

54. Types of Exercise:

_____

55. Sexually Active?

○ Yes ○ No

56. If yes, new partner in the last year?

○ Yes ○ No

57. With:

○ Men ○ Women ○ Both

Health Maintenance

58. Please indicate results (if known):

Colonoscopy:
○ Polyps ○ Diverticulosis

Tuberculosis Testing:

_____

Bone Density:

_____

Chest X-ray:

_____

Cholesterol: _____ EKG: _____ Thyroid/TSH: _____

Family History

59. Is there a history of any of the following in the family? Please tick the boxes that apply and specify relationship to patient:

- ☐ Alzheimer's disease/Dementia _____
- ☐ Behavior problems _____
- ☐ Birth defects _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Emotional problems _____
- ☐ Heart disease _____
- ☐ High blood pressure _____
- ☐ Mental retardation _____
- ☐ Stroke _____
- ☐ Thyroid problems _____
- ☐ Tuberculosis _____
- ☐ Other chronic or serious health problems _____
- ☐ Autoimmune disease(ie. Rheumatoid, lupus) _____

If "other", please specify

_____

Social History

60. Have you travelled outside of the country in the last 2 years?

- ○ Yes
- ○ No

If yes, where?

_____

Education/Employment

61. Education Level:

- ○ Less than high school
- ○ Some college
- ○ Professional or Graduate Degree
- ○ High School Diploma
- ○ College Degree

62. Employment:

- ○ Full time
- ○ Part time
- ○ Retired
- ○ Not seeking employment
- ○ Seeking employment
- ○ Student

63. Occupation:

_____

64. Exposure to chemicals/hazardous materials?

○ Yes ○ No

If yes, please explain:

_____

65. Advanced Directive?

○ Yes ○ No

66. Durable Power of Attorney?

○ Yes ○ No

67. Living Will?

○ Yes ○ No

68. Who is your primary care provider and referring provider for this visit? (Name and City/State)

_____

_____

_____

_____

69. Please list the pharmacy(pharmacies) you use (including name, address)

_____

_____

_____

_____

70. Please add attachment(s) pertaining to your health. This may include: previous lab work, diary of your symptoms, list of your surgeries, medical condtions, your doctors and etc.