H&P Intake Dr. Anthony Kim

NAME : _____

DOB: _____

AGE: _____

HANDEDNESS: (Are you right handed or left or both) ☐ R ☐ L ☐ BOTH

REASON FOR CONSULT: _____

WHO ARE YOUR DOCTORS (FULL NAME)? (need not include all, just ones who you want sent a letter)

----PRIMARY: _____

--- PAIN DOCTOR: _____

---NEUROLOGIST: _____

---ONCOLOGIST: _____

-- RHEUMATOLOGIST: _____

-- CARDIOLOGIST: _____

---WHO REFERRED YOU: _____

MEDICAL CONDITION (Circle any if you have or have had a history of the following):

- ☐ Aneurysm
- ☐ Brain tumor
- ☐ Meningioma
- ☐ Schwannoma
- ☐ Migraines
- ☐ Hx of brain trauma
- ☐ Asthma/RAD
- ☐ Seasonal allergies
- ☐ Blurry vision
- ☐ Glaucoma
- ☐ Retinal detachment
- ☐ Low thyroid
- ☐ High cholesterol
- ☐ **Diabetes**
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Cardiac stent
- ☐ Carotid stenosis
- ☐ Arrhythmia
- ☐ Atrial fibrillation
- ☐ Heart failure
- ☐ Heart attack
- ☐ Angina
- ☐ **Hypertension**
- ☐ Poor circulation
- ☐ anemia
- ☐ Hiatal hernia
- ☐ GERD
- ☐ Hx of c difficile
- ☐ GI ulcer
- ☐ Diverticulitis
- ☐ SLE or rheumatoid arthritis
- ☐ Ankylosing spondylitis
- ☐ Large prostate
- ☐ Urinary difficulty
- ☐ Frequent UTI
- ☐ Brain cancer
- ☐ NECK cancer
- ☐ Lung cancer
- ☐ Breast cancer
- ☐ Stomach cancer
- ☐ Prostate cancer
- ☐ Colon cancer
- ☐ Pancreatic cancer
- ☐ Kidney cancer
- ☐ Skin cancer
- ☐ Melanoma
- ☐ Lymphoma
- ☐ Alcohol abuse
- ☐ MRSA

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PSYCHIATRIC HISTORY

☐ Depression ☐ Anxiety ☐ Insomnia ☐ Schizophrenia

☐ Bipolar Disorder

PAST SURGICAL HISTORY:

☐ Brain craniotomy	☐ Gallbladder surgery	☐ Eye surgery/retinal
☐ Cervical fusion or arthroplasty	☐ Diverticulum surgery	☐ Hysterectomy
☐ Carotid stenosis	☐ Hip surgery	
☐ Sinus surgery	☐ Femur surgery	☐ OTHER SURGERIES:
☐ Tonsils-adenoids	☐ Knee surgery	
☐ Open heart (CABG)	☐ Shoulder surgery	_____
☐ Open heart valve replacement	☐ Wrist surgery	_____
☐ Cardiac stents	☐ Carpal tunnel	_____
☐ Stomach ulcer	☐ Lumbar laminectomy	_____
☐ Nissen fundoplication	☐ Lumbar fusion	_____

ALLERGIES to MEDICATION:

◯ No. I have no allergies to medication

◯ Yes. I have allergies to _____

☐ not sure. I am sensitive to _____

ALLERGIES to NONMEDICATION: _____

HAVE YOUR EVER SMOKED: ☐ Y ☐ N

If, so, HAVE YOU QUIT?

ARE YOU MARRIED: ☐ Y ☐ N

☐ DIVORCED ☐ WIDOWED ☐ SINGLE

DO YOU DRINK? ☐ Socially ☐ 1-2 glasses/cans daily ☐ > 3-4 drinks/beers daily

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DO YOU CURRENTLY USE? ☐ cocaine ☐ amphetamine ☐ marijuana ☐ PCP

HAVE YOU USED RECREATIONAL MEDICATIONS IN PAST:

☐ cocaine

☐ amphetamine

☐ marijuana

☐ PCP

☐ Other _____

MEDICATIONS (please type on each line):

☐ In particular, do you take blood thinners? If so, please add to this list (including homeopathic blood thinners)

(here is an example of how a medication should be written: *placebo 500 mg 1 tablet twice a day*)

ADDENDUM: Please add any additional medical or personal history of which the MD will need to be aware. Conditions such as hemochromatosis or Ehlers-Danlos, trauma, etc, apply

Please add any pertinent FAMILY HISTORY below (e.g., stroke, cancer, heart disease, neurofibromatosis, etc)

☐ heart disease ☐ stroke ☐ cancer _____ ☐ other: _____

OCCUPATION (past or present): ☐ Retired ☐ currently employed or working: _____

DATE OF COMPLETION OF FORM: _____

Thank you for filling out this form. We look forward to your visit soon!