# HISTORY INTAKE FORM

**Anthony C. Quartell, MD** **Aaron Shinbein, MD**

Patient Name _____ DOB _____ Today's Date_____

_____ _____ ☐ New Patient
Phone Number Age ☐ Established Patient

Reason for today's visit? _____
☐ Annual pap smear and well woman exam
☐ Problem, please describe: _____
Are there any questions you would like to discuss? ☐ Yes ☐ No

_____

_____

**Review of Systems:**

1. **Constitutional**
- Weight loss? o Yes o No
- Weight gain? o Yes o No

2. **Eyes**
- Visual changes? o Yes o No
- Glasses/contact lenses? o Yes o No

3. **ENT/Mouth**
- Headaches? o Yes o No
- Cold sores? o Yes o No

4. **Cardiovascular**
- Chest pains? o Yes o No
- Palpitations? o Yes o No
- Swelling/Edema? o Yes o No

5. **Respiratory**
- Shortness of breath? o Yes o No
- Coughing? o Yes o No
- Wheezing? o Yes o No

6. **Gastrointestinal**
- Diarrhea? o Yes o No
- Nausea/Vomiting? o Yes o No
- Constipation? o Yes o No

7. **Genitourinary**
- Pain with urination? o Yes o No
- Frequent urination? o Yes o No
- Incontinence? o Yes o No

8. **Skin/Breast**
- Rashes? o Yes o No
- Breast pain? o Yes o No
- Nipple discharge? o Yes o No
- Lumps in breast? o Yes o No

9. **Endocrine**
- Sugar problems? o Yes o No
- Thyroid problems? o Yes o No
- Hot flashes? o Yes o No

10. **Psychiatric**
- Depression? o Yes o No
- Anxiety? o Yes o No
- Mood Changes? o Yes o No

**Family History:**

Diabetes: o Yes o No
Heart Disease: o Yes o No
Ovarian Cancer: o Yes o No
Uterine Cancer: o Yes o No
Cervical Cancer: o Yes o No
Breast Cancer: o Yes o No
Colon Cancer: o Yes o No
Osteoporosis: o Yes o No

**Social History:**

Tobacco Use: o Yes o No
Alcohol/Drug Use: o Yes o No

# HISTORY INTAKE FORM

**Anthony C. Quartell, MD** **Aaron Shinbein, MD**

**Past History:**

Do you have any medical problems? o Yes o No
Please list:

Have you had any type of surgery? o Yes o No
Please list:

Do you have any allergies? o Yes o No
Please list:

Are you on any medications? o Yes o No
Please list:

X_____ _____
Patient Signature Date

***To be completed by the physician***

When was your last menstrual period? ____/____/____
Period occurs every ____ days and lasts ____ days.
Heavy o Yes o No
Intermenstrual bleeding: o Yes o No
Have you ever been pregnant? o Yes o No

How many times pregnant? _____
Number of children: _____
Any miscarriages or abortions? o Yes o No
Method of birth control: _____

X_____ _____
MD Signature Date

***To be completed by the physician***

Date reviewed: _____ Any Changes? o Yes o No _____
MD Signature

Date reviewed: _____ Any Changes? o Yes o No _____
MD Signature

Date reviewed: _____ Any Changes? o Yes o No _____
MD Signature

Date reviewed: _____ Any Changes? o Yes o No _____
MD Signature