MEDICAL INTAKE SHEET

NISSAN PILEST, M.D., Medical Director

Patient Name ______________________________

Date ______________________ Age __________

Allergies:
Current medications:

Reason for today's visit: (chief complaint) ______________________________

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Current or past problems with: (Review of systems)

	Yes	No	(if yes, explain)
General Health	☐	☐	______________
Eyes	☐	☐	______________
Ears/Nose/Throat/Mouth	☐	☐	______________
Heart	☐	☐	______________
Lungs	☐	☐	______________
Stomach/bowel	☐	☐	______________
Kidneys	☐	☐	______________
Arthritis/muscles/joints	☐	☐	______________
Skin	☐	☐	______________
Headaches/seizures	☐	☐	______________
Psychological disorder	☐	☐	______________
Thyroid/diabetes	☐	☐	______________
Blood/bleeding disorder	☐	☐	______________
Allergic/immunologic	☐	☐	______________

Females: are you pregnant? __yes __no planning to become pregnant? __yes __no No of children____ age(s)_______

Family History: (Past family & social history)

Mother: living/deceased___________ age____ Father: living/deceased__________ age____

Check following medical conditions that have occurred in your family:

Disease	**Self**	**Mother**	**Father**	**Blood Relative**
Allergies	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Eczema	☐	☐	☐	☐
Hay fever	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Lung disease	☐	☐	☐	☐
Malignant Melanoma	☐	☐	☐	☐
Psoriasis	☐	☐	☐	☐
Skin cancer	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐

Social History:

Do you live alone? __no __yes

Do you drink alcohol? __no __yes-frequency_______

Occupation______________________________

Do you smoke? __no __yes-frequency________

Do you use recreational drugs? __no __yes-frequency______

Hobbies/leisure activities______________________________

Reviewed______________________________

(MD signature)

Date____________________ Update________________