# Dr. David E. Schmidt - History Intake Form

**Patient Name:** _____ **Birth Date:** _____

Please answer all questions as accurately as possible. If you do not understand the question, please ask for assistance.

**Purpose of visit:** _____ If seen in E.R., when? _____

**Primary Care Doctor:** _____

Smoking (type & amount per day) _____ Alcohol (type and amount per day) _____

If former smoker, date quit: _____ **Weight** _____ **Height** _____

**Drug Allergies:** YES or NO Please list if yes: _____

**List any medications you are taking, including non-prescription drugs, like aspirin, vitamins and herbal supplements and how many milligrams:** _____ _____ _____

_____ _____ _____ _____ _____ _____

**Last Flu Vaccination Date:** _____ **Last Pneumonia Vaccination Date:** _____

**Are you currently on Blood Thinner:** YES or NO Name of Blood Thinner: _____

List of previous surgeries or major illnesses and dates: _____

## Family History:

Has any **blood relative** ever had the following:

| | | | | | |
|---|---|---|---|---|---|
| Breast Cancer ..... no | yes | High Blood Pressure ... no | yes | Kidney disease ..... no | yes |
| Melanoma …….. no | yes | Heart Disease ..... no | yes | Depression ..... no | yes |
| Stroke …… no | yes | Diabetes.....no | yes | | |

## Past Medical History:

Have **you** ever had the following?

| | | | | | |
|---|---|---|---|---|---|
| Heart disease ... no | yes | Cancer …….. no | yes | Stomach Ulcer …… no | yes |
| Arthritis ..... no | yes | Glaucoma …… no | yes | Kidney Disease …..... no | yes |
| Rheumatic Fever. no | yes | Asthma ……... no | yes | ThyroidDisease …….. no | yes |
| Anemia ……... no | yes | AIDS or HIV+ …….. no | yes | Bleeding Tendency….. no | yes |
| Tuberculosis. … no | yes | Stroke …… no | yes | Mitral Valve Prolapse...no | yes |
| Diabetes ……. no | yes | Hepatitis …… no | yes | High Blood Pressure.....no | yes |

## Review of Systems:

Do you have now or have you had within the past year:

| | | | | | |
|---|---|---|---|---|---|
| Weight change ... no | yes | Swollen feet/ankles ..... no | yes | Seizures …… no | yes |
| Dry eyes ..... no | yes | Skin rash .....no | yes | Joint or muscle pain ... no | yes |
| Chronic cough ... no | yes | Chronic diarrhea ..... no | yes | Swollen lymph nodes.. no | yes |
| Chest pain ……. no | yes | Jaundice .....no | yes | Easy bleeding..... no | yes |
| Rapid heartbeat.. no | yes | Depression .....no | yes | Easy bruising.....no | yes |

## Woman Only:

Age period began _____ Number of pregnancies _____

Date of last mammogram _____ Did you breast feed no yes

Do you do regular breast self-examinations …. no yes Breast lump or discharge no yes

**OFFICE TO COMPLETE:** **BP** _____ **Pulse** _____ **BMI:** _____

**I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO TRE BEST OF MY KNOWLEDGE.**

X _____ _____

Signature of Patient or parent, if minor Date

X _____ _____

Reviewed by: Date