Ramse
Wellness Clinic, PLLC
Convenient Care Made Simple

# Patient Intake Form

Patient Name: (Last)_____(First)_____(MI)___
Patient Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____Cellular: _____
Birthdate: _____Age: _____Sex: M F
Email Address: _____ Preferred Pharmacy _____

**In Case of Emergency:**
Name: _____Relationship: _____ Phone: _____
Patient's Spouse: _____ Phone: _____
Family Physician: _____ Phone: _____
Referred by: _____

**Past History: (**Please check if you have had any of the following):
☐ Allergies to medicines, foods, etc. _____

| | | | |
|---|---|---|---|
| ☐ High blood pressure | ☐ Allergy | ☐ Heart trouble | ☐ Anemia |
| ☐ Migraine | ☐ Bleeding (abnormal) | ☐ Dropsy | ☐ Epilepsy |
| ☐ Strokes | ☐ Cancer | ☐ Diabetes | ☐ Nervous breakdown |
| ☐ Kidney disease | ☐ Syphilis (Bad Blood) | ☐ Suicide | ☐ Obesity |
| ☐ Arthritis | ☐ Rheumatic Fever | | |

☐ Other Diseases _____
☐ Operations:( dates) _____
Current Medications (vitamins, birth control pills): _____

**Family History:**
Father: Health _____ Age _____ Deceased _____ at age _____ Cause _____
Mother: Health _____ Age _____ Deceased _____ at age _____ Cause _____
# of siblings: _____ # living_____ #deceased: _____ Cause _____

Family Diseases: Check diseases known in your blood relatives (not yourself)

| | | | |
|---|---|---|---|
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| ☐ Strokes | ☐ Cancer | ☐ Diabetes | ☐ Nervous breakdown |
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| ☐ Arthritis | ☐ Rheumatic Fever | ☐ Other _____ | |

**Examinations**:
Date of last physical examination _____ Reason _____
Hospitalizations _____ Dates _____ Reasons _____
X-Rays: Chest _____Stomach ____ Gallbladder _____ Kidney ____Colon ____ Others _____ Electrocardiogram (heart tracing) ____
Laboratory tests: _____ Date of last pap (cancer smear): _____

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**Do you now have or have had any of the following?**

Review of Systems (check any symptoms you have)

**General**
- ☐Fever
- ☐Chills
- ☐Weight Loss
- ☐Weight Gain
- ☐Night Sweats
- ☐Fatigue
- ☐Weakness

**Endocrine**
- ☐Cold intolerance
- ☐Heat intolerance
- ☐Excessive thirst
- ☐Excessive urination
- ☐Excessive sweating
- ☐Flushing

**Skin**
- ☐Rash/purple or red spots/pigment change
- ☐Hair loss
- ☐Sun sensitivity
- ☐Hives
- ☐Thickening or tightening of skin
- ☐Calcium deposits
- ☐Fingers/toes turn colors in the cold
- ☐Nodules
- ☐Psoriasis
- ☐Nail problems
- ☐Dry skin

**Neurologic**
- ☐Migraines
- ☐Headaches
- ☐Numbness/tingling
- ☐Muscle weakness
- ☐Incontinence
- ☐Seizures
- ☐Muscle cramps
- ☐Difficulty thinking or remembering

**Scalp/Head**
- ☐Hair loss
- ☐Scalp tenderness
- ☐Headache
- ☐Jaw pain with chewing

**Eyes**
- ☐Vision problems
- ☐Double Vision
- ☐Red eye or pink eye
- ☐History of pink eye as an adult
- ☐Eye Pain
- ☐Dry eyes
- ☐Sandy, gritty sensation in eyes

**Ears**
- ☐Hearing loss
- ☐Earache
- ☐Ear pain
- ☐Swollen ear
- ☐Red ear
- ☐Floppy ear
- ☐Ringing in ears
- ☐Drainage from ear
- ☐Vertigo

**Nose**
- ☐Runny nose
- ☐Nasal congestion
- ☐Nose bleeds
- ☐Deformity of nose
- ☐Swelling of nose
- ☐Red nose
- ☐Dry nose
- ☐Nose sores
- ☐Loss of sense of smell
- ☐Sinusitis

**Mouth**
- ☐Sores in mouth
- ☐Dry mouth
- ☐Dental problems
- ☐Loss of taste
- ☐Difficulty swallowing
- ☐Bleeding gums
- ☐Sore throat
- ☐Hoarseness/change in voice

**Allergy**
- ☐Frequent sneezing
- ☐Seasonal allergies
- ☐Increased infections

**Lungs**
- ☐Shortness of breath
- ☐Cough
- ☐Coughing up blood
- ☐Wheezing
- ☐Chest pain with breathing/pleurisy

**Heart**
- ☐Chest pain
- ☐Stabbing chest pain/pericarditis
- ☐Irregular or rapid heart rate
- ☐Lightheadedness/Passing out
- ☐Sleep on more than 2 pillows due to shortness of breath
- ☐Awakened by shortness of breath
- ☐Leg/ankle swelling
- ☐Color changes in legs/feet
- ☐Leg cramps with walking
- ☐Heart murmur

**GI/Abdomen**
- ☐Abdominal pain
- ☐Heartburn
- ☐Nausea
- ☐Vomiting
- ☐Difficulty swallowing
- ☐Diarrhea
- ☐Constipation
- ☐Blood in stools
- ☐Black, sticky stools
- ☐Mucous in stools
- ☐Jaundice
- ☐History of food poisoning

**Genitourinary/Urology**
- ☐Pain/burning with urination
- ☐Difficulty urinating
- ☐Urinary incontinence
- ☐Cloudy urine
- ☐Blood in urine
- ☐History of STDs

**Women only****
- ☐Pre-eclampsia or high blood pressure during pregnancy
- ☐History of miscarriage
- ☐Vaginal discharge
- ☐Vaginal ulcers

**Men only****
- ☐Penile discharge
- ☐Penile ulcers
- ☐Prostate trouble

**Blood/Lymph**
- ☐Swollen lymph nodes (status post biopsy)
- ☐Blood clots
- ☐Bleeding tendency
- ☐Bruising
- ☐Transfusions

**Psychology**
- ☐Depression
- ☐Anxiety/Panic Attacks
- ☐Insomnia or Disturbed sleep
- ☐Wake up unrefreshed
- ☐High stress level

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**Financial Policy:**
Thank you for selecting Ramsey Wellness Clinic, PLLC for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements.

_____ _____

Patient's Signature Date