☐Paul V. Spiegl M.D., / ☐Tedman L. Vance, M.D., /☐ Daniel A. Nicholson, M.D./ ☐ Yolanda Scott, M.D.

Patient Intake questionnaire

PLEASE PRINT

Patient Name: ____ Date: _______________

*Date of Birth: __________________ *Gender:___________ Appointment Date: _______________

*Race/Ethnicity: _____ Asian/Pacific Islander _____ Caucasian/White _____ Black/African American
_____ Arab Americans _____American Indian/Alaska Native _____ Hispanic/Latino _____ Other

*Preferred Language:____________________________
*Email Address: ____________________________

How were you referred to Dr. Spiegl, Dr. Vance, Dr. Nicholson or Dr. Scott?

☐ Worker's Compensation Attorney Referral – Name of Attorney: ____________________________

☐ Liability Attorney Referral - Name of Attorney: ____________________________

☐ Patient Referral - Name of Patient ____________________________

☐ Physician Referral - Name of Physician ____________________________

☐ Hospital Referral – Name of Hospital: ____________________________

☐ Online Advertisement

☐ Other: ____________________________

MEDICAL HISTORY:

☐ Aids/HIV	☐ Coronary Artery Disease	☐ Hypertension	☐ Peptic ulcer disease
☐ Alcoholism	☐ Crohn's disease	☐ Inflammatory bowel disease	☐ Psoriasis
☐ Alzheimer's	☐ Degenerative joint disease	☐ Juvenile rheumatoid arthritis	☐ PVD
☐ Anemia	☐ Depression	☐ Kidney disease	☐ Renal disease
☐ Angina	☐ Diabetes	☐ Liver disease	☐ Rheumatoid arthritis
☐ Arthritis	☐ Drug abuse	☐ Lyme disease	☐ Scoliosis
☐ Asthma	☐ DVT	☐ Migraine headaches	☐ Seizure disorder
☐ Atrial fibrillation	☐ Fibromyalgia	☐ Multiple sclerosis	☐ Sleep apnea
☐ Benign prostatic hypertrophy	☐ Gallbladder disease	☐ Myocardial infarction	☐ SLE
☐ Cancer	☐ GERD	☐ Obesity	☐ Spinal stenosis
☐ Cerebrovascular accident	☐ Gout	☐ Osteoarthritis	☐ Spondyloarthropathy
☐ Congestive heart failure	☐ Hepatitis	☐ Osteoporosis	☐ Thyroid disease
☐ COPD	☐ Hyperlipidemia	☐ Parkinson's disease	☐ Valvular disease

SURGICAL HISTORY:

☐ ACL surgery	☐ Back Surgery	☐ Hernia Repair	☐ Small Bowel Resection
☐ Angioplasty	☐ CABG	☐ Hip Arthroplasty	☐ Thyroidectomy
☐ Angio with stent	☐ Cardiac Valve Replacement	☐ Hip Replacement	☐ Tonsillectomy
☐ Appendectomy	☐ Carpal Tunnel Release	☐ Knee Replacement	
☐ Arthroscopy Ankle	☐ Cataract Extraction	☐ Laminectomy	**Gender Specific**
☐ Arthroscopy Elbow	☐ Cholecystectomy	☐ LASIK	☐ Cesarean Section
☐ Arthroscopy Hip	☐ Colectomy	☐ Meniscus Surgery	☐ Hysterectomy
☐ Arthroscopy Knee	☐ Colostomy	☐ Muscle Biopsy	☐ Mastectomy
☐ Arthroscopy Wrist	☐ Discectomy	☐ ORIF	
☐ Arthroscopy Shoulder	☐ Gastric Bypass	☐ Pacemaker	

ADDITIONAL MEDICAL / SURGICAL HISTORY: (include right or left, year of surgery, or additional surgeries)

____

____

FAMILY HISTORY: (includes all illnesses and conditions, state of health, cause of death)

☐ NO KNOWN FAMILY HISTORY

MOTHER: ____

FATHER: ____

BROTHERS: ____

SISTERS: ____

SOCIAL HISTORY:

MARITAL STATUS ________________ # OF CHILDREN _______ SONS ____ DAUGHTERS ____

OCCUPATION ______________________ EMPLOYMENT STATUS ______________________

*SMOKING ☐ Current Everyday Smoker ☐ Current Occasional Smoker ☐ Never Smoked ☐ Former Smoker

TYPE ________ PACKS PER DAY ________ # OF YEARS ________ YEAR QUIT ________

ALCOHOL ☐ YES ☐ NO / FREQUENCY __________________

CAFFEINE ☐ YES ☐ NO CHECK√ TYPE ☐ COFFEE/ ☐ SODA/ ☐ CHOCOLATE/ ☐ TEA

***ALLERGIES TO MEDICATION:** ☐ NO KNOWN ALLERGIES

MEDICATION ________________ BRAND __________ REACTION ________________

MEDICATION ________________ BRAND __________ REACTION ________________

MEDICATION ________________ BRAND __________ REACTION ________________

***MEDICATIONS:** ☐ NO MEDICATIONS

MEDICATION ________________ DOSAGE __________ FREQUENCY ________________

MEDICATION ________________ DOSAGE __________ FREQUENCY ________________

MEDICATION ________________ DOSAGE __________ FREQUENCY ________________

***PREFERRED PHARMACY:**

Name: ____

Address: ______________________________________

City: ________________ State: ________ Zip Code: ________

NURSES DOCUMENTATION:

HEIGHT/FEET __________ __INCHES ____________ WEIGHT ____________

CURRENT PHYSICIANS:

Primary Care ____

Cardiologist ____

Infectious Disease ____

Endocrinologist ____

Pulmonary Specialist ____