Steven Rosenzweig, M.D.

New Patient Intake Form

Visit Date:

Patient Name: **Date of Birth:**

Current Gender Identity:

Reason for Consultation. Please list the major issue(s) here:

Referred by:

Past Medical History. Please list all medical conditions, diagnoses, or medical problems for which you have been treated.

Past Surgical History. Please list all major surgeries with dates:

Past Major Physical Injuries with dates:

Healthcare Team.

Name of your Primary Care Provider:

Other key physicians / healthcare providers who treat you:

Allergies.

Medication(s) and nature of reaction:

Other (food, environmental, etc) and nature of reaction

Medications – List ALL Prescription and Over-the-Counter or attach list. Please include doses.

Supplements / Herbal Medicines / Homeopathics – list here or attach list. Please include doses.

Advance Directive

Have you appointed a health care proxy (given someone medical power of attorney)? Name of proxy:

Do you have a living will?

Do you need more information about advance directives?

Patient Name:_____

Family Medical History. Medical problems of your family members (including cancer, early heart disease, high blood pressure, diabetes)?

Father:	Child:
Mother:	Child:
Brother:	Other:
Sister:	Other:

Social History and Lifestyle Inventory: <u>Skip any questions</u> you feel uncomfortable about answering.

Tobacco: Present use? Past use?

Alcohol: How many alcoholic beverages to you drink per week?

Significant use of recreational drugs?

Past or present chemical dependencies?

Diet: Do you adhere to a particular diet? Do you avoid certain foods? Do you have any eating problems or restrictions?

Tell about your daily routine, work, studies, responsibilities, interests:

With whom do you live? Is your living situation safe and wholesome?

Exercise – type, intensity and frequency:

Mind body practices (meditation, yoga, Tai Qi, prayer, etc.):

Other wellness practices – what else do you do to support your health and well-being?

Major life stressors and challenges:

Do you have a good social support or family, friends or neighbors?

What gives your life meaning? How close to your life purpose are you living?

What else would it be helpful for Dr. Rosenzweig to know about you?

Patient Name:_____

Symptom Review – Please check off any **CURRENT** symptoms

Note: Some items ask you to rank your symptoms on scale of 0 (nothing) to 10 (most extreme imaginable).

General	
Diminished wellbeing (circle score)	0-1-2-3-4-5-6-7-8-9-10
Fatigue/tiredness (circle score)	0-1-2-3-4-5-6-7-8-9-10
Drowsiness (circle score)	0-1-2-3-4-5-6-7-8-9-10
Sleep: Problem falling asleep	☐
Sleep: Problem staying asleep	☐
Unexplained weight loss or gain	☐
Pain	
Pain severity now (circle score)	0-1-2-3-4-5-6-7-8-9-10
Average past week (circle score)	0-1-2-3-4-5-6-7-8-9-10
Maximum severity past week:	0-1-2-3-4-5-6-7-8-9-10
Eyes	
Blurry vision	☐
Dry eyes	☐
Ears / Nose / Throat / Sinuses	
Ringing in ears	☐
Sinus infections	☐
Other	☐
Heart / Circulation	
Palpitations or irregular pulse	☐
Chest discomfort with exercise or exertion	☐
Leg swelling	☐
Lungs	
Shortness of breath (circle score)	0-1-2-3-4-5-6-7-8-9-10
Wheezing	☐
Other:	☐
Digestion / Elimination	
Loss of appetite (circle score)	0-1-2-3-4-5-6-7-8-9-10
Nausea (circle score)	0-1-2-3-4-5-6-7-8-9-10
Abdominal pain / cramps	☐
Abdominal bloating	☐
Excessive belching or flatus	☐
Constipation	☐
Diarrhea	☐
Bladder / Kidneys / Urination	
Frequent urine infections	☐
Urination difficulties (pain, urgency)	☐
Sexuality	
Sexuality issues to discuss with physician?	☐

Gynecological	
Abnormal menstruation	☐
Severe premenstrual symptoms	☐
Muscles / Bones / Joints	
Muscle cramps or spasms	☐
Joint pain / stiffness / swelling	☐
Nervous system	
Headaches	☐
Numbness or burning or shooting pain	☐
Difficulty concentrating or remembering	
Other	☐
Allergies / Immune System	
Seasonal allergies	☐
Chemical allergies	☐
Frequent infections	☐
Hormonal / Endocrine	
Cold intolerance	☐
Heat intolerance	☐
Excessive thirst	☐
Excessive hunger	☐
Eyebrow hair loss	☐
Blood (Hematologic)	
Abnormal bruising	☐
Abnormal bleeding	☐
Skin	
Rashes	☐
Eczema	☐
Other	☐
Psychiatry/ Psychology	
Anxiety/restlessness: (circle score)	0-1-2-3-4-5-6-7-8-9-10
Depressed / sad: (circle score)	0-1-2-3-4-5-6-7-8-9-10
Other	
Anything else?	

Thank you!