

PATIENT INTAKE SHEET

Date of Visit: _____

Patient Name: _____

DOB: _____ Age: _____

Chart #: _____

Athena ID#: _____

Prescription Plan Name: _____
(i.e. Insurance Company)

Insurance ID#: _____

Height _____ Weight _____

Visit: New Follow-up Second Opinion ER Follow-up (Date in ER _____)

I understand that I am entering into a contractual relationship with medical practice/physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost of and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by medical practice/physician, I (the patient) and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against medial practice/physician.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I (the patient) and/or my representative agree to use American Board of Medical Specialties certified expert medical witness(es) in the same or similar specialty as physician. Furthermore, I agree that these expert witnesses will adhere(s) to the guidelines and/or code of conduct defined by the specialty society(ies) for expert witnesses in the area(s) of medicine that would typically have the background and experience to make an opinion on such a case. In further consideration for this I, (the physician), agree to the same stipulations.

PATIENT'S SIGNATURE

PHYSICIAN'S SIGNATURE

Reason for being seen (List detailed symptoms, location and progress, and description of pain)

Example: I am having pain in my right hip with radiation down to my knee, and weakness.

Approximate date of onset _____ Have you had surgery for this problem (What, Where, and When)?

Have you had any of the following performed for this problem?

X-Ray MRI CT Scan EMG Other, please specify _____

Where and When? _____

Cortisone injections? Yes No # of injection _____ Dates _____

Pharmacy Name: _____ Address: _____

City: _____ Phone Number: _____

Medications (please list name and dosage)

For this problem: _____

For other conditions or illness: _____

Please list allergies to medications or state NONE (Name Reaction) _____

CONTINUED NEXT PAGE

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CONTINUED FROM PREVIOUS PAGE

Have you had physical therapy for this problem? Yes No

Sports in which you participate _____ Daily 3-5 x Weekly Occasionally

Occupation _____

Current Work Status: Employed Unemployed On Disability

Past Medical History--Have you been treated for any of the following problems?

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart | <input type="checkbox"/> Lungs | <input type="checkbox"/> Liver |
| <input type="checkbox"/> Kidney | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Blood Pressure (high/low) | <input type="checkbox"/> Diabetes (Insulin? Y/N) | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Cancer (Where? _____) | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Infections | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Sleep Apnea |

List what surgery(s) you have had? (Approximate dates) _____

Complications from surgery or anesthesia? _____

Blood transfusions in the past? Yes No

Social History: Tobacco: Yes How many years? _____ No Quit (when?) _____
 Cigarette Pipe Cigar Chew

Alcohol use: Heavy Moderate Social
 Occasional None

Substance Abuse: Yes No Type _____

Family History--Problems in direct relatives:

- | | | |
|--|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Sickle Cell | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Obesity | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Psychiatric Problems | |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Liver Disease | |

Referred for Opinion & Consult by _____

PATIENT'S SIGNATURE

PHYSICIAN'S SIGNATURE