MEDICAL INTAKE FORM

Name: ______________________________

PATIENT INFORMATION

Date: ______________________________

Medication Allergies: Do you have any allergies to medication(s)?

Yes   No

If yes, list medication(s) and reaction(s):

Hospitalizations / Surgeries (describe):

Injuries / Accidents (describe):

MEDICAL HISTORY

Do you now, or have you in the past, had problems with any of the following:

<table>
<thead>
<tr>
<th>SKIN</th>
<th>HEAD</th>
<th>EYES</th>
<th>EARS, NOSE / SINUS</th>
<th>MOUTH / THROAT</th>
<th>NECK</th>
<th>RESPIRATORY</th>
<th>GASTRONTESTINAL</th>
<th>GENITORINARY</th>
<th>NEUROLOGICAL</th>
<th>MUSCULOSKELETAL</th>
<th>HEMATOLOGIC</th>
<th>PSYCHIATRIC</th>
<th>OTHER</th>
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</thead>
<tbody>
<tr>
<td>Rashes</td>
<td>Head Injury</td>
<td>Blurred or Double Vision</td>
<td>Ear Pain or Infections</td>
<td>Hoarseness</td>
<td>Swelling</td>
<td>Asthma</td>
<td>Ulcers</td>
<td>Kidney Stones</td>
<td>Headaches</td>
<td>Joint Pain</td>
<td>Anemia</td>
<td>Irritability</td>
<td>Mononucleosis</td>
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<td></td>
<td>Concussion</td>
<td>Eye Infections</td>
<td>Bloody Nosess</td>
<td>Pain</td>
<td>Pain</td>
<td>Cough</td>
<td>Jaundice</td>
<td>Hernia</td>
<td>Seizures</td>
<td>Muscle Pain</td>
<td>Leukemia</td>
<td>Nervousness</td>
<td>Fibromyalgia</td>
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<td></td>
<td>Loss of Consciousness (Passing Out)</td>
<td>Swelling of Hands of Feet</td>
<td>Hearing Loss</td>
<td>Pain</td>
<td>Lumps</td>
<td>Bronchitis</td>
<td>Heartburn</td>
<td>Blood in Urine</td>
<td>Stiffness</td>
<td>Stiffness Or Swelling</td>
<td>Bruise Easily</td>
<td>Depression or Mood Changes</td>
<td>HIV</td>
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<td></td>
<td></td>
<td>Hay fever / Allergies</td>
<td></td>
<td></td>
<td>High Blood Pressure</td>
<td>Hepatitis</td>
<td>STD</td>
<td>Dizziness</td>
<td></td>
<td>Blood Clots</td>
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<td>Cancer or Tumors</td>
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<td></td>
<td>Swelling / Positive Test</td>
<td>IBS</td>
<td>Painful Urination</td>
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<td>Blood In Urine</td>
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<td></td>
<td>Tuberculosis</td>
<td>Nausea or vomiting</td>
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<td>Blood Clots</td>
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<td></td>
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<td>Rheumatic Fever</td>
<td>Gallbladder Disease</td>
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</table>

List any other illness or symptom not included above:

Females Only: Are you pregnant?

Yes   No

Menstruation: Regular Yes     No  If so, list activity and frequency:

Do you have a regular exercise program?

Yes   No  If so, list activity and frequency:

Are you currently, or have you been sexually active?

Yes   No If yes, do you use contraception?

Yes   No If so, who?

Have you ever been assaulted verbally, sexually, or physically?

Yes   No If yes, did you sustain any injuries (please list):

Do you smoke or use smokeless tobacco?

Yes   No If so, list number of packs per day:

Do you drink alcoholic beverages?

Yes   No If so, list amount and frequency:

Are you currently seeing a therapist, counselor, psychologist or psychiatrist?

Yes   No

Have you been outside of the U.S. within the last 12 months?

Yes   No

Do you ever withhold food, exercise to excess, binge and purge, or use laxatives/diuretics to lose weight?

Yes   No If yes, please explain:

FAMILY HISTORY

Does anyone in your family have any of the following? (Include parents, grandparents, siblings, and children)

- Alcoholism
- Heart Disease
- Kidney disease
- Diabetes
- Thyroid Disease
- Ulcers
- Mental Illness
- Bleeding Disorder
- Epilepsy
- Arthritis
- High Blood Pressure
- Other:

Please check one: From:

Utah County   Utah   Out of State   International   Faculty   Staff   International