DARTMOUTH-HITCHCOCK • MANCHESTER

Department of General Surgery

PATIENT INTAKE FORM

Name: Date:
DOB:

Reason for your visit today:

Please list past surgeries, if any:

Surgery	Date	Doctor	Hospital

Please list any medical problems (examples: high blood pressure, heart disease)

Have you had a recent colonoscopy or flexible sigmoidoscopy? Yes___ No____
If yes then please list the date:_____ and facility:_____

Have you had any recent X-rays, such as a CT scan? Yes_____ No_____
Date:_____ Facility:_____

Do you have any family history (mother, father or siblings) for colon cancer or colon polyps?
If yes, please explain _____

Do you smoke? Yes_____ No_____
How many packs per day? _____
How many years have you smoked? _____

Do you drink alcoholic beverages? Yes_____ No_____
How many drinks per week? _____

Are you diabetic? Yes_____ No _____

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Review of symptoms: please circle all that apply:

General:	Recent change in usual weight, Weakness, Fatigue, Fever
Skin:	Rash, Lumps, Sores, Itching, Dryness, Color change, Change in hair or nails
Head:	Headaches, Head Injury
Eyes:	Vision problems, Glasses, Pain, Redness, Excessive tearing, Double vision, Blurred vision, Spots, Specks, Glaucoma, Cataracts
Ears:	Change in hearing, Ringing sound, Room spins, Dizzy, Earache, Infection, Discharge, Hearing aids
Nose/Sinuses:	Frequent colds, Nasal stuffiness, Discharge, Itching, Hay Fever, Nose bleeds, Sinus trouble
Mouth/Throat:	Bleeding gums, Dentures, Sore Throat, Dry Mouth, Sores, Hoarseness
Neck:	Lumps, “Swollen Glands”, Pain, Stiffness, Goiter
Breasts:	Lumps, Pain, Discomfort, Nipple Discharge, Change in Self-Examination, Do Not Perform Self Examination
Respiratory:	Cough, Sputum, Blood in sputum, Wheezing, Asthma, Bronchitis, Emphysema, Pneumonia, Tuberculosis, Pleurisy
Cardiac:	Heart trouble, High blood pressure, Rheumatic Fever, Heart murmur, Chest pain, Shortness of breath, Shortness of breath at night
Gastrointestinal:	Trouble swallowing, Heartburn, Change in appetite, Nausea, Vomiting, Regurgitation, Vomiting of blood, Indigestion, Change in bowel movements (frequency, color, size), Rectal bleeding, Constipation, Hemorrhoids, Diarrhea, Abdominal pain, Food intolerance, Gas, Gallbladder trouble, Hepatitis
Urinary:	Change in frequency of urination, Excessive urination, Get up in the middle of the night to urinate, Blood in urine, Dribbling, Incontinence, Urinary infection, Stones
Genital:	Hernia, Sores, Discharge, Rash, Pain, Bleeding, Itching, Problems with sexual function
Vascular:	Leg pain, Leg cramps, Varicose veins, Blood clots in the past
Musculoskeletal:	Muscle pain or joint pain, Stiffness, Arthritis, Gout, Backache
Neurological:	Fainting, Blackouts, Seizures, Weakness, Paralysis, Numbness or loss of sensation, Tingling, “Pins and needles”, Tremors
Hematological:	Anemia, Easy bruising, Bleeding, Past transfusions, Bad reaction to previous transfusions
Endocrine:	Thyroid trouble, Heat or cold intolerance, Excessive sweating, Diabetes, Excessive thirst or hunger, Excessive urination
Psychiatric:	Nervousness, Tension, Depression, Other psychiatric problems, Memory problems

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Medication List

Name: _____Date of Birth: _____ Date: _____

Please list your current medications below.

Be sure to list both over the counter and prescription medications, as well as vitamins and other supplements.

Medication Name	Dose	When do you take this? am? pm? Bedtime?	Prescribed by who	What do you take this for?
Example- PREVACID	30 MG	1 am and 1 pm	Dr. Feelgood	heartburn

Please list your allergies below:

Allergic to:	What happens when you take this:

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