Usman Ahmad, D.O.
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# PATIENT INTAKE FORM

## PATIENT INFORMATION

Name: _____ Today's Date: _____
Last Name First Name Middle Initial

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Soc. Sec. # _____ Gender: ☐ M ☐ F

Home Phone: _____ Mobile Phone: _____ Email: _____

In case of emergency, who should be notified? _____ Phone: _____

## PHARMACY INFORMATION

Please write down your current pharmacy information

Name: _____

Phone #: _____

Address: _____

## PCP INFORMATION

Please write down your PCP information

Name: _____

Phone #: _____

Address: _____

## HOW DID YOU FIND OUT ABOUT US?

☐ Referral – Doctor Name: _____
☐ Friend/Family: _____
☐ Website
☐ Google
☐ Facebook
☐ Other: _____

## ASSIGNMENT AND RELEASE

- I, the undersigned, certify that I (or my dependent) have insurance coverage with the insurance I have provided.
- I hereby assign my insurance benefits to be paid directly to the physician
- I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize & give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.
- I authorize my provider's office to contact me by telephone to remind me of my appointments.
- A fee for no shows may apply.

**Signed:** _____ **Date:** _____

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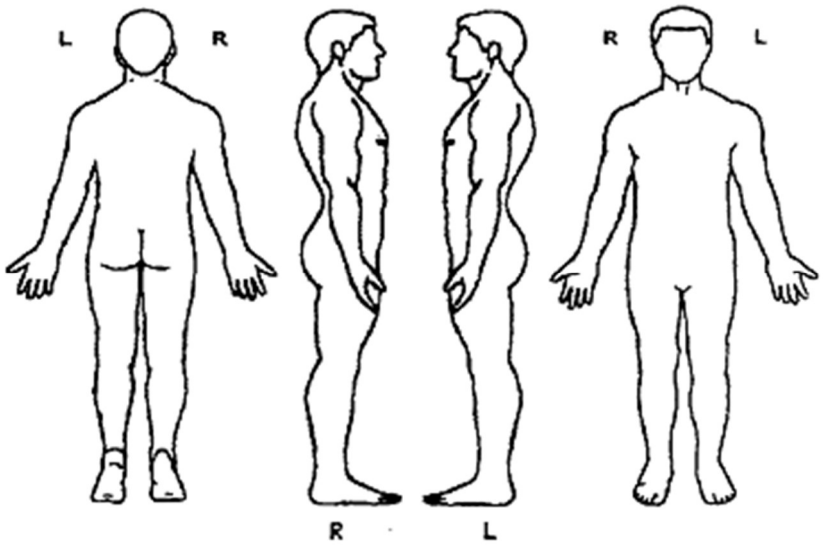
## PAIN DIAGRAM

Mark the areas on your body where you feel the described sensations. Include all affected areas. Mark as follows:

**A**- Ache **B**- Burning **N**- Numbness **P**- Pins & Needles **S**- Stabbing **O**- Other




**Primary Complaint:** _____

When did your pain start? _____

What caused your pain? _____

Check **ALL** that apply to your symptoms:

**Pain Quality:**
- ☐ sharp
- ☐ aching
- ☐ burning
- ☐ shooting
- ☐ constant
- ☐ intermittent

**Increase Pain:**
- ☐ sitting
- ☐ standing
- ☐ walking
- ☐ bending forward
- ☐ bending backward
- ☐ lifting
- ☐ Coughing/sneezing
- ☐ Cold/heat
- ☐ Other _____

**Decrease Pain:**
- ☐ sitting
- ☐ lying down
- ☐ walking
- ☐ standing
- ☐ ice/heat
- ☐ exercise
- ☐ Relaxation
- ☐ Medication_____
- ☐ Other_____

**Associated Symptoms:**
- ☐ weakness
- ☐ numbness
- ☐ tingling
- ☐ fever
- ☐ weight loss
- ☐ bowel/bladder problems
- ☐ insomnia
- ☐ pain wakes at night
- ☐ sexual dysfunction
- ☐ other:

_____
_____
_____

On a scale from one to ten, how do you rate your pain now? (circle)

**1 2 3 4 5 6 7 8 9 10**

Does your pain radiate anywhere (arms or legs)?_____

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## MEDICATIONS

☐ None ☐ I presently take the following: (Please print clearly)

| Name of Medication | Amount Per day | Reason | Last dose taken | How long |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## ALLERGIES

☐ NO KNOWN DRUG ALLERGIES

| Medication Name: | Reaction: |
|---|---|
| | |
| | |
| | |
| | |
| | |
| **Other:** | |

Intravenous Dye: ☐ Y ☐ N Shellfish: ☐ Y ☐ N Anesthesia: ☐ Y ☐ N

## FAMILY HISTORY

Have your parents had any of the following?

Mother: ☐ Alive ☐ Deceased
☐ Y ☐ N Diabetes ☐ Y ☐ N Other:_____
☐ Y ☐ N Heart Disease
☐ Y ☐ N Cancer

Father: ☐ Alive ☐ Deceased
☐ Y ☐ N Diabetes ☐ Y ☐ N Other:_____
☐ Y ☐ N Heart Disease
☐ Y ☐ N Cancer

## SURGICAL HISTORY

Surgeries: List type & date

_____
_____
_____
_____

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## PAST MEDICAL HISTORY

List all medical conditions you have had

| | | | | | |
|---|---|---|---|---|---|
| Head Trauma | ☐ Y ☐ N | Bronchitis | ☐ Y ☐ N | UTI's | ☐ Y ☐ N |
| Blindness | ☐ Y ☐ N | COPD | ☐ Y ☐ N | Arthritis | ☐ Y ☐ N |
| Cataracts | ☐ Y ☐ N | Pleuritis | ☐ Y ☐ N | Gout | ☐ Y ☐ N |
| Glaucoma | ☐ Y ☐ N | Pneumonia | ☐ Y ☐ N | M/S Injury | ☐ Y ☐ N |
| Wears Glasses/Contacts | ☐ Y ☐ N | Cirrhosis | ☐ Y ☐ N | Epilepsy | ☐ Y ☐ N |
| Hearing Aids | ☐ Y ☐ N | GERD | ☐ Y ☐ N | Seizures | ☐ Y ☐ N |
| Allergic Rhinitis | ☐ Y ☐ N | Gallbladder Disease | ☐ Y ☐ N | Severe Headaches/Migraines | ☐ Y ☐ N |
| Sinus Infections | ☐ Y ☐ N | Heartburn | ☐ Y ☐ N | Stroke | ☐ Y ☐ N |
| Dentures | ☐ Y ☐ N | Hemorrhoids | ☐ Y ☐ N | Bipolar Disorder | ☐ Y ☐ N |
| Aneurysm | ☐ Y ☐ N | Hepatitis | ☐ Y ☐ N | Depression | ☐ Y ☐ N |
| Angina | ☐ Y ☐ N | Hiatal Hernia | ☐ Y ☐ N | Suicidal attempts | ☐ Y ☐ N |
| DVT | ☐ Y ☐ N | Jaundice | ☐ Y ☐ N | Goiter | ☐ Y ☐ N |
| Dysrhythmia | ☐ Y ☐ N | Ulcers | ☐ Y ☐ N | Hyperlipidemia | ☐ Y ☐ N |
| HTM | ☐ Y ☐ N | Hernia | ☐ Y ☐ N | Thyroid Disease | ☐ Y ☐ N |
| Murmur | ☐ Y ☐ N | Incontinence | ☐ Y ☐ N | Anemia | ☐ Y ☐ N |
| Heart Attack | ☐ Y ☐ N | Nephrolithiasis | ☐ Y ☐ N | Cancer Type_____ | ☐ Y ☐ N |
| Other Heart Disease | ☐ Y ☐ N | Other kidney Disease | ☐ Y ☐ N | HIV/AIDS | ☐ Y ☐ N |
| Asthma | ☐ Y ☐ N | STD's | ☐ Y ☐ N | Tuberculosis | ☐ Y ☐ N |

**OTHER:**_____

## REVIEW OF SYSTEMS

Check if you have any of the following:

**CONSTITUTIONAL**
___ Fever
___ Night Sweats
___ Chills
___ Cold Intolerance
___ Fatigue
___ Daytime Somnolence
___Weight Gain
___Weight Loss
___Polydipsia

**EYES**
___ Change in Vision
___ Loss of Vision
___ Blurred Vision
___Diplopia (Double Vision)

**EARS**
___ Difficulty hearing
___ Hearing Loss
___ Ear Pain/Ache
___ Ear Drainage
___ Tinnitus

**NOSE**
___Nasal Congestion
___Nasal Discharge
___Epistaxis (Nosebleeds)
___Sneezing
___Snoring

**NECK**
___Neck Pain
___Neck Stiffness
___Neck Lumps
___ Neck Swelling

**MOUTH/THROAT/VOICE**
___ lip Sores
___ Mouth Sores
___ Tongue Sores
___ Sore Throat
___ Dysphagia

**RESPIRATORY**
___ Dyspnea
___Cough
___Hemoptysis (Coughing up blood)
___ Wheezing

**CARDIOVASCULAR**
___ Chest Pain
___ Palpitations
___ Dyspnea at rest
___ Dyspnea with activity
___ Lower Extremity Edema

**GASTROINTESTINAL**
___ Abdominal Pain
___ Rectal Pain
___ Nausea
___ Vomiting
___ Vomiting Blood
___Diarrhea
___Blood in Stool

**GENITAL/REPRODUCTIVE**
___ Change in Libido
___ Dyspareunia
___ Difficulty achieving erection
___ Difficulty reaching orgasm
___ Currently having menstrual cycles

**URINARY**
___ Dysuria
___ Hematuria
___Urinary Hesitancy
___ Difficulty initiating Urine stream
___ Urine Dribbling
___ Increased Frequency
___ Decreased Frequency
___ Polyuria
___Urinary Incontinence

**DERMATOLOGIC/ INTEGUMENTARY**
___ Change in hair texture
___ Change in skin texture
___ Hair Loss
___ Dry Skin
___ Itching
___Hives
___Rash
___Bruising

**MUSCULOSKELETAL**
___ Muscle Pain
___ Back Pain
___ Tender Points
___ Muscle Cramps
___ Muscle Weakness
___Decreased Muscle Strength
___Limb Paralysis
___Difficulty Walking
___Limp

**NEUROLOGICAL**
___Headaches
___Vertigo
___Lightheadedness
___Fainting
___Blackout(s)
___Numbness
___Tingling
___Tremor
___Lack of Coordination
___Weakness
___Difficulty Speaking
___Memory Loss
___Difficulty Concentrating

**PSYCHIATRIC**
___Change in mood
___Depression
___Sadness interfering with Function
___Anxiety
___Nervousness
___Sleep Disturbance
___Suicidal Ideation
___Hopelessness
___Worthlessness
___Delusions
___Hallucinations

**HEMATOLOGIC/LYMPHATIC**
___Easy Bruising
___Difficulty stopping blood flow
___Lymph Node Enlargement

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## SOCIAL HISTORY

Smoking Status: ☐ Every Day ☐ Someday ☐ Former ☐ Heavy Tobacco Smoker ☐ Light Tobacco Smoker ☐ Never Smoker

Alcohol Intake: ☐ Do Not Drink ☐ Drink Daily ☐ Frequently Drink ☐ Hx of Alcoholism ☐ Occasional Drink

Drug Abuse: ☐ IVDU ☐ Illicit Drug Use ☐ No Illicit Drug Use

Cardiovascular: ☐ Eat Healthy Meals ☐ Regular Exercise ☐ Take Daily Aspirin

Safety: ☐ Household Smoke Detector ☐ Keep firearms in home ☐ Wear Seatbelts

Sexual Activity: ☐ Exposure to STI ☐ Homosexual Encounters ☐ Not Sexually Active ☐ Safe Sex Practices ☐ Sexually active

**All of the above information is true and accurate to the best of my knowledge.**

**Signature:** _____ **Date:** _____