

## **Union Physician Services**

## **Patient Intake Form**

Last Name:	First Nan	ne: N	/II: Date	of Birth:
Age: Male or Female:	So	ocial Security #:		
Home Address:				
Street	City	Stat	e	Zip
Home Phone:	Cell Phone: _	W	Vork Phone:	
Email Address:				
Employer:			anguage Spoker	າ:
Ethnicity:   Non-Hispanic Race:  African American	•		Native American	□ Other
Referring Doctor:			<del></del>	
Marital Status:   Married	_			
Spouse Name:	Date of	Birtn:		
	Duima			
		ry Insurance	#	
nsurance Co:	Policy #	Gro	oup #	<del></del>
ubscribers Name:				
Address if Different than Patient:	Phone	:	Relationship t	o Patient:
Street City	State Zip		<del>-</del>	<del></del>
2.13,	•	lary Insurance		
nsurance Co:		•	un #	
Subscribers Name:		DC		
Address if Different than Patient:				
Street City	State Zip			
•	,			
Emergency Contact (EC) / Relea	ase of Information (	ROI)- Please Check	the Boxes that A	Apply:
Name of Person to Contact in o	-	-		
Name:		=		□FC □R
Name:		Relation		
Name:			nship:	
	:		<b>p.</b>	
Communication:   Message ma	av he left □ Answerir	ng Machine □ Famil	v Memher	
	e Power of Attorney?			
	c. ower or Attorney:		ie:	
			cionship:	
Print: Si	gnature:	· · · · · · · · · · · · · · · · · · ·	Date:	



Patient Initials:	DOB: _	Height:	Weight: II
Current Symptoms/ Ro	eason fo	or Visit :	Length of time:
1.			
2.			
3.			
Are your Symptoms?			
	Yes	No When	
Work Related?			
Injury Related?			
Did you stop working?			<del></del>
Did you return?			
Recent Testing? (Last (	6 Montl	hs) □No □Yes	
Test Name			Date
1.			
3.			
Current Symptoms: Please	e Check A	All that Apply	
□ Abdominal Pain		□ Frequent Urination	□ Nosebleeds
☐ Back Pain		☐ Hair Loss	□ Numbness/ Tingling
□ Blood in Urine		☐ Headaches	□ Pain/ Bleeding during Sex
□ Bloody/ tarry stool		☐ Hemorrhoids	□ Painful Urination
□ Bruise Easily		□ Hernia	□ Phobias
☐ Change in bowel habits		□ Hives	□ Rashes
□ Chest Pain		☐ Hoarseness	□ Ringing in Ears
□ Cold numb feet		□ Indigestion/ Heartburn	□ Sexual Dysfunction
□ Constipation		□ Insomnia	☐ Shortness of Breath
☐ Convulsions/ Seizures		□ Joint Pain	☐ Sinus Trouble
□ Cough		□ Leg Pain	□ Sore Throat
□ Diarrhea		□ Loss of Appetite	□ Swollen Ankles
☐ Difficulty Swallowing		☐ Lumps/ Masses	☐ Tooth/ Gum Trouble
☐ Dizziness/ Fainting		☐ Memory Loss	☐ Tremors
☐ Ear Infection		□ Moodiness	☐ Urethral Discharge
☐ Failing Vision		☐ Muscle Weakness	☐ Varicose Veins
□ Fatigue		□ Nausea/ Vomiting	□ Weight Loss
□ Fever		□ Nervousness	<b>5</b>
□Foot Pain		□ Night Sweats	



Patient Initials:	_ DOB:					
<b>Previous Surgery</b>			Hospi	tal	Date	е
Problems with Anes	thesia in the I	past?   N  Y-Explain				
Do you have a Pacer	-	·			_	
•						
Please list ally sello	us injunes				_	
essell illians						
Family History	Illn	ess			Deceased	Living
Father						
Mother						
Brother						
Sister						
Children						
Other						
		Social H	History			
Do you live alone? □Y	′ □ N- who?					
Number of Children-						
Do you exercise regula						
Which is your Domina	nt Hand? 🗆 Rig	ght □Left				
Highest grade level co	mpleted?	<del></del>				
Occupation?						
Are you on a special di	iet?					
Do you use any of the	_	ase check all that apply				
	Yes	Never	Quit	Amoui	nt per Day	<u> </u>
Recreational Drugs						
Alcohol						
Tobacco						
Caffeine						
Please complete if app						
Are you planning a pre						
What kind of contrace		ising currently?				
Are you pregnant now						
When was your last m	enstrual cycle?					



Patient Medical History	Yes	No	Yes	No		Ye	s N
AIDS		Eczema			Multiple Sclerosis		
Anemia		Emphysema			Mumps		
Anxiety		Epilepsy			Muscle Disorder		
Arrhythmia		Eye/ Ear Disorder			Neuropathy		
Arthritis		Genetic Defects			Osteoporosis		
Asthma		Gout			Parkinson's Disease		
Birth Defect:		Hayfever/ Allergies			Phlebitis		
Blood Disorder/ Clot		Heart Attack			Pneumonia		
Bone/ Joint Disorder		Heart Disease			Polio		
Bronchitis		Heart Murmur			Prostate Disease		
Cancer: Type		Hepatitis: Type			Psoriasis		
Chicken Pox		Herpes			Rubella		
Cirrhosis/ Liver		High Blood Pressure			Seizures		
Colitis		Jaundice			Skin Disease		
Congestive Heart Failure		Kidney Failure			Sleep Apnea		
COPD		Kidney Stones			Stroke		
Crohn's Disease		Lactose Intolerant			Tetanus		
Deep Vein Thrombosis		Low Blood Pressure			Thyroid Disease		
Depression		Lung Disease			Tuberculosis		
Diabetes		Measles			Ulcers		
Diptheria		Mental Illness			Venereal Disease		
Diverticulosis		Migraines			Other:		
· -	<del></del>				ail In: <sub>Dose</sub>	Frequen	—— Су
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Local Pharmacy:Current Medications						Frequence	cy
Current Medications						Frequence	cy
· -						Frequence	cy

Metal Allergy? □N □Y