radiology partners
HOUSTON

Patient Intake: Personal Information

Name: _____Date:_____
Address: _____
Phone: _____ Email: _____
DOB: _____ Sex: _____
Who referred you? _____

Medical History

Medications (include dosage/frequency taken): _____
_____
_____
Past Surgical History:_____
_____
Medical problems within immediate family: _____
_____
Allergies?_____
Recent vaccinations?_____
Tobacco Use: (Y/N)_____ Have you ever smoked? (Y/N) _____ How often? _____
Alcohol Use: (Y/N) _____ How often? _____
Recent hospitalizations? (Include date and reason): _____
Past Medical History (please check all that apply):

☐ Diabetes (I or II)	☐ High Blood Pressure	☐ Heart attack
☐ High Cholesterol	☐ Asthma	☐ Heart stents
☐ Crohn's Disease	☐ Sleep apnea	☐ Pacemaker
☐ Ulcerative colitis	☐ COPD	☐ Congestive Heart Failure
☐ Reflux	☐ Hepatitis (A, B or C)	☐ Stroke
☐ Liver cirrhosis	☐ Kidney disease	☐ Overactive bladder
☐ Arthritis	☐ Chronic pain	☐ Urinary retention
☐ Anxiety/Depression	☐ Headaches/Migraines	☐ Urinary incontinence
☐ Panic Disorder	☐ Cataracts	☐ Bleeding disorders
☐ Bipolar Disorder	☐ Glaucoma	☐ Anemia
☐ Cancer (please list below):	☐ Retinal detachment	☐ Autoimmune disorders (please list):
_____ _____	☐ Macular degeneration	_____ _____

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Please circle any of the symptoms below you may be currently experiencing:

General: weight loss fever chills weakness fatigue
Other: _____

Eyes: vision loss blurred vision double vision changes in color vision
Other: _____

Ears/Nose: hearing loss ringing in ears sneezing congestion runny nose sore throat
Other: _____

Cardiovascular: chest pain chest discomfort irregular heart beat swelling
Other: _____

Respiratory: shortness of breath cough mucous production pain/discomfort when breathing
Other: _____

Gastrointestinal: nausea vomiting diarrhea abdominal pain reflux bloating
Other: _____

Genitourinary: frequency of urination blood in urine bladder infection pain when urinating
change in bowel or bladder control urgency hesitation abnormal urine color
Other: _____

Musculoskeletal: muscle pain joint pain back pain stiffness cramps fracture
Other: _____

Neurologic: headache dizziness paralysis headache fainting or near fainting episodes
Other: _____

Hematologic: anemia easily bruising enlarged lymph nodes history of transfusions
Other: _____

Endocrine: sweating cold or heat intolerance recent hair loss recent change in weight
Other: _____

Psychiatric: depression anxiety panic trouble sleeping change in mood or behavior
Other: _____

Skin: asthma rash hives itching eczema discoloration
Other: _____