Advocate Illinois Masonic Medical Center

Patient Intake Form

Date: ________/_______/_____ **Tel**: ______-______-________ **DOB**: ______________________

Name: ________________________________ Address: ______________________ ______________________ ____________

Street City Zip

SSN ____________________________

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Primary MD: ______________________ **Referring MD**: ______________________

Address: ______________________ **Address**: ______________________

______________________ ______________________

______________________ ______________________

Tel: ______-______-________ **Tel**: ______-______-________

Fax: ______-______-________ **Fax**: ______-______-________

***** Review of Systems*** **

Yes	No		Yes	No		Yes	No	
☐	☐	Fever	☐	☐	Anemia	☐	☐	Blood in stool
☐	☐	Weight loss	☐	☐	Persistant cough	☐	☐	Joint swelling
☐	☐	Double / Loss of vision	☐	☐	Night sweats	☐	☐	Joint pain
☐	☐	Tearing	☐	☐	Problems breathing	☐	☐	Tremor
☐	☐	Loss of hearing	☐	☐	Wheezing	☐	☐	Difficulty speaking
☐	☐	Dizziness	☐	☐	Chest pain	☐	☐	Seizures
☐	☐	Frequent nose bleeds	☐	☐	Heart palpitations	☐	☐	Fainting
☐	☐	Problems swallowing	☐	☐	Swelling of extremities	☐	☐	Mood changes
☐	☐	Mouth or throat ulcers	☐	☐	Nausea	☐	☐	Memory loss
☐	☐	Easy bruising	☐	☐	Vomiting	☐	☐	Urinary or bowel loss
☐	☐	Open sores	☐	☐	Diarrhea	☐	☐	Painful urination
☐	☐	Enlarged lymph nodes	☐	☐	Loss of appetite	☐	☐	Frequent urination

***** Medical History*** **

☐ Hypertension	☐ Bleeding disorder	☐ Low Thyroid	☐ Diverticulosis	☐ Bronchitis
☐ Diabetes	☐ Reflux / GERD	☐ Prostate disease	☐ Heart disease	☐ Stomach ulcers
☐ Stroke	☐ Depression	☐ Menopause	☐ Heart attack	
☐ Asthma	☐ Anxiety	☐ Irritable bowel	☐ Emphysema	

Other: ____

***** Surgical History*** **

☐	Gallbladder	☐	Heart surgery or stent	☐	Intestine resection
☐	Appendix	☐	Tonsils		
☐	Spine surgery	☐	Hysterectomy		

Other: ____

***** Personal, Family, Social History*** **

Family History

Alive	Deceased	
☐	☐	Mother
☐	☐	Father

Number of siblings: _______

List any major disease in the family ____

Social History

☐ Tobacco use: (packs per day) _______

☐ Alcohol use

☐ What is your job: ____________________________________

Medication allergies

____

____

____

Current Medications:

_________________ _________________ _________________

_________________ _________________ _________________

_________________ _________________ _________________

Patient Signature ________________________**Date:** ___________ **MD/RN Signature** ____________________________