



**Patient Intake Form**  
**Georgia Medical Specialists**

**General**

Patient Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Mi) \_\_\_\_\_  
Patient Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F  
Country of Birth: \_\_\_\_\_ Country of Parents' Birth: \_\_\_\_\_  
Education: Elementary High School/Technical School 2-yr College 4-yr College Graduate School  
(Circle the highest level achieved)

**Employment Information:**

Patient Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Work phone No: \_\_\_\_\_ Ext. \_\_\_\_\_  
Social Security: \_\_\_\_\_ Driver's License No: \_\_\_\_\_

**In Case of Emergency:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
Patient's Spouse: \_\_\_\_\_ Phone: \_\_\_\_\_  
Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Referred by: \_\_\_\_\_

**Past History:** (Please check if you have had any of the following):

- |   |   |  |   |                                     |
|---|---|--|---|-------------------------------------|
| <input type="checkbox"/> Allergies, Type: _____     | <input type="checkbox"/> Birth defects or abnormalities | <input type="checkbox"/> Exposed to tuberculosis |   |                                     |
| <input type="checkbox"/> Measles                    | <input type="checkbox"/> Scarlatina                     | <input type="checkbox"/> Influenza               | <input type="checkbox"/> Mumps          | <input type="checkbox"/> Diphtheria |
| <input type="checkbox"/> Rheumatic                  | <input type="checkbox"/> Fever German Measles (3 day)   | <input type="checkbox"/> Polio                   | <input type="checkbox"/> Whooping Cough |                                     |
| <input type="checkbox"/> Frequent Colds             | <input type="checkbox"/> Chickenpox                     | <input type="checkbox"/> Tonsillitis             |   |                                     |
| <input type="checkbox"/> Scarlet Fever              | <input type="checkbox"/> Pneumonia                      | <input type="checkbox"/> Diabetes: Type: _____   |   |                                     |
| <input type="checkbox"/> Cancer, Type: _____        | <input type="checkbox"/> Other Diseases _____           |  |   |                                     |
| <input type="checkbox"/> Operations :( dates) _____ |   |  |   |                                     |

Current Medications (vitamins, birth control pills): \_\_\_\_\_

Allergies to medicines, foods, etc. \_\_\_\_\_

**Family History:**

Father: Health \_\_\_\_\_ Age \_\_\_\_\_ Deceased \_\_\_\_\_ at age \_\_\_\_\_ Cause \_\_\_\_\_  
Mother: Health \_\_\_\_\_ Age \_\_\_\_\_ Deceased \_\_\_\_\_ at age \_\_\_\_\_ Cause \_\_\_\_\_  
# of siblings: \_\_\_\_\_ # living \_\_\_\_\_ #deceased: \_\_\_\_\_ Cause \_\_\_\_\_



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**Family Diseases:** *Check diseases known in your blood relatives (not yourself)*

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Allergy                 | <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Anemia            |
| <input type="checkbox"/> Migraine            | <input type="checkbox"/> Bleeding (abnormal)     | <input type="checkbox"/> Dropsy        | <input type="checkbox"/> Epilepsy          |
| <input type="checkbox"/> Strokes             | <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Nervous breakdown |
| <input type="checkbox"/> Kidney disease      | <input type="checkbox"/> Syphilis or (bad blood) | <input type="checkbox"/> Suicide       | <input type="checkbox"/> Obesity           |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Rheumatic               | <input type="checkbox"/> Fever         |  |
| <input type="checkbox"/> Other _____         |  |  |  |

**Examinations:**

Date of last physical examination \_\_\_\_\_ Reason \_\_\_\_\_  
 Hospitalizations \_\_\_\_\_ Dates \_\_\_\_\_ Reasons \_\_\_\_\_  
 X-Rays: Chest \_\_\_\_\_ Stomach \_\_\_\_\_ Gallbladder \_\_\_\_\_ Kidney \_\_\_\_\_ Colon \_\_\_\_\_ Others \_\_\_\_\_  
 Electrocardiogram (heart tracing) \_\_\_\_\_  
 Laboratory tests: \_\_\_\_\_ Date of last pap (cancer smear): \_\_\_\_\_

**Do you now have or have had any of the following?**

- |   |   |  |   |  |
|---|---|--|---|--|
| <input type="checkbox"/> Itching                  | <input type="checkbox"/> Eczema                 | <input type="checkbox"/> Hives                     | <input type="checkbox"/> Joint pains        | <input type="checkbox"/> Muscle aches  |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Limitation of motion   | <input type="checkbox"/> Backache                  | <input type="checkbox"/> Leg pains          | <input type="checkbox"/> Heel Pains    |
| <input type="checkbox"/> Pain or stiffness (neck) | <input type="checkbox"/> Goiter                 | <input type="checkbox"/> Swelling, enlarged glands | <input type="checkbox"/> Asthma             |  |
| <input type="checkbox"/> Lung disease             | <input type="checkbox"/> Raise sputum           | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Bronchitis         | <input type="checkbox"/> Heart trouble |
| <input type="checkbox"/> High blood pressure      | <input type="checkbox"/> Shortness of breath    | <input type="checkbox"/> Palpitation or fluttering | <input type="checkbox"/> Chest pain         |  |
| <input type="checkbox"/> Lips or nails turn blue  | <input type="checkbox"/> Tire easily            | <input type="checkbox"/> Swelling of ankles        | <input type="checkbox"/> Indigestion        |  |
| <input type="checkbox"/> Nausea or vomiting       | <input type="checkbox"/> Abdominal pain         | <input type="checkbox"/> Gas or bloating           | <input type="checkbox"/> Diarrhea           |  |
| <input type="checkbox"/> Hard bowel movements     | No. of bowel movements - daily _____            |  | <input type="checkbox"/> Colitis            |  |
| <input type="checkbox"/> Jaundice                 | <input type="checkbox"/> Hemorrhoids (piles)    | <input type="checkbox"/> Bleeding or black stools  | <input type="checkbox"/> Hernia             |  |
| <input type="checkbox"/> Urinary System           | <input type="checkbox"/> Kidney disease         | <input type="checkbox"/> Bladder disease           | <input type="checkbox"/> Kidney stones      |  |
| <input type="checkbox"/> Painful urination        | <input type="checkbox"/> Pus or blood in urine  | <input type="checkbox"/> Albumen or sugar in urine | <input type="checkbox"/> Dribbling of urine |  |
| <input type="checkbox"/> Varicose veins           | <input type="checkbox"/> Nervousness or anxiety | <input type="checkbox"/> Trouble sleeping          | <input type="checkbox"/> Headaches          |  |
| <input type="checkbox"/> Bored or depressed       | <input type="checkbox"/> Nervous breakdown      | <input type="checkbox"/> Fainting                  | <input type="checkbox"/> Convulsions        |  |
| <input type="checkbox"/> Numbness                 | <input type="checkbox"/> Loss of consciousness  | <input type="checkbox"/> Neuritis or Neuralgia     | <input type="checkbox"/> Paralysis          |  |

**Menstrual History:**

Menstruation began at age \_\_\_\_\_ 28 day cycle? \_\_\_\_\_ If no, how many days? \_\_\_\_\_  
 Duration of bleeding \_\_\_\_\_ Pain with periods \_\_\_\_\_  
 Amount of flow \_\_\_\_\_ Light \_\_\_\_\_ Med. \_\_\_\_\_ Heavy \_\_\_\_\_  
 Date of 1st day of last menstrual period \_\_\_\_\_  
 Bleeding between periods \_\_\_\_\_ Bleeding after intercourse: \_\_\_\_\_  
 Irritation or discharge \_\_\_\_\_ Itching or burning \_\_\_\_\_



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**Weight History**

When did you first become overweight? (your age then) \_\_\_\_\_ (year) \_\_\_\_\_

How did your weight gain start? Describe any circumstances: \_\_\_\_\_

What do you think is the cause of your weight problem? \_\_\_\_\_

Your present weight: \_\_\_\_\_ your weight goal: \_\_\_\_\_ height: \_\_\_\_\_

What was your highest weight? (excluding pregnancy) \_\_\_\_\_ your age then \_\_\_\_ # of years ago \_\_\_\_\_

What was your lowest weight? \_\_\_\_\_ your age then \_\_\_\_ # of years ago \_\_\_\_\_

Have you ever stayed the same weight for 10 years or more? Yes:/ No

Have you attempted to lose weight before? \_\_\_\_\_ most lbs lost: \_\_\_\_ how long it took: \_\_\_\_\_

Describe previous methods of weight loss (e.g. diets, pills, injections, hypnosis, acupuncture)

Describe your results: \_\_\_\_\_

Where and when do you do most of your overeating? \_\_\_\_\_

Please make any comments that you think might be helpful:

Do you currently have any medical concerns? Please List: \_\_\_\_\_

**Financial Policy:**

Thank you for selecting Georgia Medical Specialists for your health care needs. We are honored to be of service to you. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Name