BAPTIST HEALTH®
MEDICAL GROUP

2125 State Street, Suite 5
New Albany, IN 47150
(812) 944-BONE (2663)

Patient Intake Form

It is important you complete all sections

Name: _____ Appointment Date: _____

Date of Birth: _____ Job Title/Occupation: _____
(If, disabled, include date disability began)

Referred by: _____

Male: _____ Female: _____ **Handed:** Right or Left **Height** _____ **Weight** _____

Is this visit/injury due to a motor vehicle accident? _____No _____Yes

Is this visit/injury due to a Workers Comp claim or work related accident? _____No _____Yes

If yes, please explain: _____

STOP: If you answered yes to one of the above questions, please see the front desk staff before going any further.

What is your **CHIEF COMPLAINT** today? _____

How **LONG** have you had this problem? _____

What **TREATMENT** have you had for this problem? _____

_____

What makes the problem **BETTER**? _____

What makes the problem **WORSE**? _____

Rate your pain with 0 as no pain: 0 1 2 3 4 5 6 7 8 9 10

List all **SURGERIES** you have had with dates: _____None

_____

_____

_____

List all **MEDICAL** problems you have: _____None

_____

_____

_____

(Please complete page 2 on the back)

List anything you may be **ALLERGIC** to: _____None

List all **MEDICATIONS & Supplements** you are currently taking: _____

Caffeine: _____No _____Yes-How much? _____

Do you Exercise? _____No _____Yes- How often and type?_____

Do you Smoke cigarettes? _____No _____Yes- How Much? _____

Do you drink Alcohol? _____No _____Yes- How Much? _____

Do you use non-prescribed Drugs? _____No _____Yes- Which ones? _____

Have you had a colonoscopy? _____No _____Yes-Date of most recent:_____

Have you had eye surgery? _____No _____Yes-Date & Type:_____

Have you had a mammogram? _____Not Applicable _____No _____Yes-Date _____

Have you had a tubal ligation? _____Not Applicable _____No _____Yes-Date_____

Have you had a hysterectomy? _____Not Applicable _____No _____Yes-Date_____

List Medical problems in your **FAMILY & family member** (Mother/Father/Sister/Brother/Grandparents-Paternal/Maternal)

Cancer_____ Diabetes_____ Heart Disease_____

Hypercholesterolemia (High Cholesterol)_____

Hypertension (High Blood Pressure)_____

Other: _____

Do you have any of the following now?

Fever/Chills:_____ Chest Pain:_____ Stomach Ulcers:_____

Constipation:_____ Nausea/Vomiting:_____ Headache:_____

Abdominal Pain:_____ Urinary Problems:_____ Difficulty Breathing:_____

Dizziness:_____ Diarrhea:_____

Signature: _____

By signing I certify that all the answers provided above are true to the best of my knowledge and if any untruthful answers are given that I will be held financially responsible for any services, supplies, equipment, office visit/or physician services that are billed to me.