

**CSUMB Campus Health Center  
New Patient Intake Form**



CALIFORNIA STATE UNIVERSITY  
**Monterey Bay**

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Your answers on this form will help your clinician understand your medical concerns and conditions better. Best estimates are fine if you cannot remember specific details.

**REASON FOR VISIT:** \_\_\_\_\_  
\_\_\_\_\_

**IMMUNIZATIONS:**

When was your most recent Tetanus immunization? \_\_\_\_\_

When was your most recent Influenza immunization? \_\_\_\_\_

When was your most recent pneumococcal immunization? \_\_\_\_\_

Are you up to date on all immunizations?  Yes  No

**WOMEN'S GYNECOLOGIC HISTORY:**

1st day of your most recent period: \_\_\_\_\_

Is there a possibility you may be pregnant?  Yes  No

**ALLERGIES or REACTIONS TO MEDICATIONS/FOODS/OTHER AGENTS:**

Allergic to:	Reaction or Side Effect

No Known Drug Allergies

**MEDICATIONS:** Prescription and non-prescription medicines, vitamins, and birth control pills:

Medication	Dose	Times per day

Not currently taking medications

**PERSONAL MEDICAL HISTORY:**

Please indicate whether you have had any of the following medical problems:

- |   |   |
|---|---|
| <input type="checkbox"/> Alcoholism                                 | <input type="checkbox"/> Diabetes: <i>type II</i>             |
| <input type="checkbox"/> Abnormal Pap smear                         | <input type="checkbox"/> High cholesterol                     |
| <input type="checkbox"/> Blood disorder                             | <input type="checkbox"/> Hypertension (High blood pressure)   |
| <input type="checkbox"/> Cancer (Malignancy)                        | <input type="checkbox"/> Myocardial Infarction (Heart attack) |
| <input type="checkbox"/> Congenital Heart disease                   | <input type="checkbox"/> Stroke                               |
| <input type="checkbox"/> Depression/Anxiety                         | <input type="checkbox"/> Thyroid problem                      |
| <input type="checkbox"/> Diabetes: <i>type I (requires insulin)</i> | <input type="checkbox"/> Other: _____                         |

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**SURGICAL HISTORY** (Please list all prior operations and dates):

Operation	Date

**FAMILY HISTORY**

List any of your family members (mother, father, brother, sister, son, daughter, maternal grandparents, and or paternal grandparents) that have had any of the following illnesses:

Disease Name	Mother	Father	Sister	Brother	Son	Daughter	Maternal Grand-Father	Maternal Grand-Mother	Paternal Grand-Father	Paternal Grand-Mother
Alcoholism										
Alzheimer's										
Arthritis										
Asthma										
Cancer										
COPD										
Depression										
Diabetes										
Heart Attack										
Heart Disease										
High Cholesterol										
Hypertension										
Hypothyroidism										
Other:										

**SOCIAL HISTORY**

Tobacco Use	Alcohol Use	
<p><b>Cigarettes</b>            Current: Smoker: <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Never  <input type="checkbox"/> Quit: Date _____            packs/day _____ # of yrs _____</p> <p><b>Other Tobacco:</b>  <input type="checkbox"/> Cigar <input type="checkbox"/> Chew <input type="checkbox"/> Pipe <input type="checkbox"/> Snuff            Are you interested in quitting? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Second Hand Smoke:</b>            Smoke exposure in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Do you drink alcohol?  <input type="checkbox"/> Yes <input type="checkbox"/> No,            # drinks/week _____</p>	<p>Is alcohol use a concern            for you or others?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
	Drug Use	
	<p>Do you use any recreational drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No            If yes, indicate what type _____</p> <p>Have you ever used needles? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

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**REVIEW OF SYMPTOMS you are experiencing today:** Please indicate either negative or positive by placing a check (√) in the boxes provided.

**NEG/POS Constitutional**

- Recent fever
- Recent chills
- Unexplained fatigue/weakness

**NEG/POS Eyes**

- Blurred vision
- Eye pain
- Eye drainage

**NEG/POS Ears/Nose/Throat/Mouth**

- Difficulty hearing
- Continuous post nasal drip
- Hoarseness of voice change
- Sore Throat
- Ear Pain

**NEG/POS Cardiovascular**

- Chest pains/discomfort
- Palpitations

**NEG/POS Respiratory**

- Chronic Cough
- Wheezing
- Acute Cough
- Shortness of breath

**NEG/POS Gastrointestinal**

- Heartburn
- Acid reflux
- Nausea/vomiting
- Diarrhea
- Abdominal pain

**NEG/POS Genitourinary**

- Painful urination
- Nighttime urination
- Frequent urination
- Discharge: Penis or Vagina

**NEG/POS Musculoskeletal**

- Muscle pain
- Joint pain
- Joint stiffness
- Recent back pain

**NEG/POS Skin**

- Rashes or Itching
- Fungal nail infection
- Warts
- Dry Skin

**NEG/POS Neurological**

- Headaches
- Memory loss
- Fainting
- Dizziness
- Numbness

**NEG/POS Blood/Lymphatic**

- Unexplained lumps/nodes
- Excessive bleeding
- Easy bruising

**NEG/POS Endocrinology**

- Excessive sweating
- Thyroid trouble
- Cold/heat intolerance
- Increase thirst/appetite

**NEG/POS Allergy/Immunologic**

- Seasonal Allergies
- Altered Immune System

**NEG/POS Psychiatric**

- Anxiety/stress
- Sleep problems
- Nervousness/Depression

**PHARMACY:**

Pharmacy for today's medications? \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_