Northwell Health℠
Physician Partners

200 West 13th Street 6th Floor
NY, NY 10011
(646)665-6784

Patient Name: _____ DOB:_____

Patient Intake and History Form

Please provide the following information. This form is confidential and will be entered into your medical record.

Past Medical History *Please check any condition you have now or have had in the past* ☐**No Past Medical History**

☐Asthma	☐Cancer(type_____)	☐Arthritis (location_____)
☐COPD	☐Neuropathy	☐Herniated Disc
☐Diabetes	☐Parkinson's Disease	☐Lupus
☐Heart Disease	☐Prolonged Steroid Treatment	☐Osteoporosis
☐ High Cholesterol	☐Seizure/Epilepsy	☐Rheumatoid Arthritis
☐ Hypertension	☐Stroke	☐Spinal Stenosis
Other_____	Other_____	Other_____

Surgery and Hospitalization History ☐**No Past Surgery/Hospitalizations**

Reason for Surgery/Hospitalization	Hospital Name (if available)	Date (approximate)

Family History *Have any family members had the following?* ☐**No Pertinent Family History**

	Yes	No	If Yes, who?	Type	Location
Arthritis/DJD	☐	☐			
Cancer	☐	☐			
Genetic Disease	☐	☐			
Osteoporosis	☐	☐			

Social History

Living Situation	☐ Alone ☐ Family	☐ House ☐ Apartment ☐ Stairs
Occupation		Currently Working? ☐ Yes ☐No
Smoking Hx	☐ Current Smoker:	*packs per day*? ☐ <1 ☐ 1-2 ☐ 3+
		how long? ☐ < 1 year ☐ 1-10 years ☐ 10+years
	☐ Former Smoker	☐ Never a Smoker
Do you drink alcohol?	☐Regularly ☐Occasionally	☐ Rarely ☐ Never *If Yes, have you ever been treated* ☐ Yes ☐No
Do you use recreational drugs?	☐Regularly ☐Occasionally	☐ Rarely ☐ Never *If Yes, have you ever been treated* ☐ Yes ☐No
Do you exercise?	☐Regularly ☐Occasionally	☐ Rarely ☐ Never Intensity ☐ High ☐ Low
List Activities		

Patient Name: _____ **DOB:**_____

Allergies *Please check all that apply* ☐**No Known Allergies**

☐ Shellfish ☐ Contrast Dye ☐ Latex ☐Medications _____
☐ Seasonal ☐ Latex ☐ General/Local Anesthetic ☐ Other _____

Current Medications *Please list all medications including vitamins and supplements* ☐**No Current Medications**

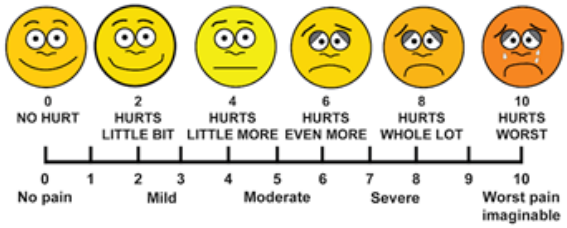
1.	2.	3.
4.	5.	6.

Have you recently taken or used? ☐ NSAIDS (Aleve, Ibuprofen, Aspirin) ☐ Tylenol ☐ Ice/Compression ☐ Other OTC

Reason for you visit today: _____

Current Height: _____ft _____in Current Weight: _____lbs

Pain Assessment *Please circle the picture/number to describe the severity of your pain at this time.*



Location of Pain: _____

Describe Your Pain ☐ intermittent ☐ constant ☐ localized ☐ radiating ☐ other _____

How long have you had pain? ___Days ____Weeks ____Months ____Years

Review of Systems *Please check any of the following symptoms you have experienced recently or are experiencing now*

☐Chills	☐Feeling Tired	☐Fever	☐Recent Weight Gain
☐Discharge	☐Eye Pain	☐Sight Problems	☐Redness
☐Dec Hearing	☐Nasal Discharge	☐Nosebleeds	☐Sore Throat
☐SOB at rest	☐Cough	☐SOB w/exertion	☐Leg Swelling
☐Abdominal Pain	☐Constipation	☐Diarrhea	☐Heartburn
☐Urinary Frequency	☐Urinary Urgency	☐Incontinence	☐Abnormal. Vaginal Bleeding
☐Arthralgias	☐Joint Pain	☐Joint Stiffness	☐Joint Swelling
☐Breast Pain	☐Breast Lump	☐Skin Lesions	☐Change in a mole
☐Headache	☐Dizziness	☐Fainting	☐Convulsions
☐Anxiety	☐Depression	☐Sleep Disturbances	☐Muscle Weakness
☐Deepening Voice	☐Feeling Weak	☐Hot Flashes	
☐Easy Bleeding	☐Easy Bruising	☐Swollen Glands	

_____
Signature of Patient Date

_____
Patient Representative Name Signature Date