Dr. Mary Steiner 2700 Fait Ave, Baltimore, MD 21224 INTAKE SYMPTOMS FORM

Reason for visit:____

____

____

When did pain begin?____

How did pain begin?____

Describe the symptoms: (Circle all that apply)

*Sharp pain *Dull pain *Stabbing pain *Numbness *Tingling *Ache

*Other (describe):____

Describe the frequency/duration of symptoms: (Circle all that apply)

*All night *Morning *Afternoon *Evening *Daily *Weekly *Monthly

*Other (describe):____

Review of systems: Please circle <u>any</u> symptoms that apply to <u>you</u>.

Cardiovascular: Heart palpitations * High blood pressure * Chest pain * Calf pain * Other:_________________

Respiratory: Trouble breathing * Asthma * Shortness of breath * Smoking History: (length of time)__________

Gastrointestinal: Digestive problems * Ulcers * Reflux (GIRD) * Nausea * Other:_________________________

Genitourinary: Painful urination * Changes in urination color/frequency * Painful coitus * Other:_____________

Neurological: Trouble concentrating * Numbness * Headaches * Tremors * Other:______________________

Psychiatric: Depression * Hallucinations * Schizophrenia * Memory loss * Other:________________________

Endocrine: Menstrual problems * Night sweats * Diabetes * Thyroid dysfunction * Other:_________________

Hematological: Bruising easily * MRSA * Anemias * Swelling in legs * Other:___________________________

Allergic/Immunological: Seasonal allergies * Frequent infections * Other:_______________________________

Eyes/Ears/Nose/Throat: Vision trouble * Hearing dysfunction * Colds/flu * Swallowing difficulty * Other:____

Operations (list date and type):____

Review of family history: Using the "review of systems above" as a guide, please note any pertinent family history below:____

____

____

Social History: Please circle and describe all that apply to you:

Exercise: Frequency ____ per week/month * Weight training * Cardio * Sports:__________________________

Activities of Daily Living: Please describe all that are currently being affected by your condition:

Sleeping:____

Exercising:____

Job/Work:____

Driving:____

Family life:____

Hygiene (bathing, dressing, teeth):____

Signature:____ **Date:** _____/_____/_____