VANDERBILT UNIVERSITY MEDICAL CENTER

NAME:
DOB: / /
DATE: / /
MRN:

Primary Care for Women

Vanderbilt School of Nursing Faculty Practice

Patient Intake Form

What is the one most important symptom or concern you would like addressed today?

_____

Do you have any other concerns if time allows?

_____

Have you had any changes to your medical history, allergies, or medications since your last visit?

_____

Please circle any symptoms you currently have if severe or particularly troublesome:

GENERAL
Unexplained weight loss
Weight gain
Excessive thirst
Excessive fatigue

SKELETAL
Joint swelling
Gout
Muscle weakness

SKIN
Skin/hair changes
New/changing moles

NEUROPSYCHIATRIC
Severe headaches
Numbness or tingling
Feeling "blue"
Crying spells
Suicidal thoughts
Desire psychiatric help /counseling

EYE, EAR, NOSE, & THROAT
Vision changes
Hearing changes
Allergies
Swollen glands
Hoarseness
Snoring
Difficulty swallowing

LUNGS
Bad cough
Coughing up blood
Wheezing
Difficulty breathing

HEART
Chest pain
Irregular heart beat
Murmur
Ankle swelling

GASTROINTESTINAL
Loss of appetite
Frequent heartburn
Abdominal pain
Nausea
Vomiting
Persistent constipation
Frequent diarrhea
Rectal bleeding

GENITOURINARY
Pain with urination
Passing blood
Kidney stones
Urinating at night
Sexual function problems

SEXUAL
Problem with sex life
Request HIV/STI testing

Is there anything else we should know about you to help care for you better?

_____