

## Returning Patient Annual Exam Intake Form

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

Address: \_\_\_\_\_

Telephone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

E-mail address: \_\_\_\_\_

Has your insurance changed since we last saw you \_\_\_\_\_ No \_\_\_\_\_ Yes

Please list any specific questions or concerns for Dr. Jacobs today:

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Have you experienced any significant changes in your health, been hospitalized or undergone surgery since you were last seen here?

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Have there been any changes in your family history?

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Please let us know if you have been experiencing any of the following:

- Weight Change
- Fever/Chills
- Difficulty Sleeping
- Problems with your Eyes
- Hearing Loss
- Sinus Congestion
- Chest Pain/Palpitations
- Coughing/Wheezing/Difficulty Breathing
- Bloody Sputum
- Nausea/Vomiting
- Diarrhea
- Constipation
- Bloody Stools
- Frequent Urination
- Painful/Bloody Urine
- Leakage of Urine
- Bleeding Between Periods
- Heavy Vaginal Bleeding
- Vaginal Discharge
- Low Sex Drive/Sexual Dysfunction
- Recurrent Yeast Infections
- Painful Intercourse
- Pelvic Pain
- Skin Rashes
- Breast Pain/Discharge/Mass
- Seizures
- Fainting Episodes
- Mood Changes/Depression/Anxiety
- Heat/Cold Tolerance
- Excessive Thirst or Urination
- Hot Flashes
- Abnormal Bruising/Bleeding

Please List any allergies to medications:

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Please list all medications below:

Medication	Dosage	Frequency	Prescribed By

Please list all Vitamins/Supplements and Herbals below:

Supplement	Dose	Frequency	Manufacturer

Is there anything else we should know for your appointment today?

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