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**NEW PATIENT INTAKE FORM**

Today's Date: \_\_\_\_\_ MGH Unit # \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Patient name: \_\_\_\_\_

Preferred phone number: \_\_\_\_\_  **Work**  **Cell**

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

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Primary care physician: \_\_\_\_\_

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

Name of person/physician that referred you: \_\_\_\_\_

Phone: \_\_\_\_\_ Other: \_\_\_\_\_

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Has your birth mother ever had breast cancer:  **Yes**  **No**

Does your birth mother or father have a history of diabetes?  **Yes-Mother**  **No-Mother**

**Unknown-Mother**  **Yes-Father**  **No-Father**  **Unknown-Father**

Does your birth father have a history of heart disease?  **Yes**  **No**  **Unknown**

How tall are you? \_\_\_\_\_ What is your current weight? \_\_\_\_\_  
(Example: 5 feet, 8 inches)

**SMOKING STATUS (cigarettes/tobacco)**

Select response:

**I have never smoked**  **I have smoked for ~ years smoked: \_\_\_\_\_**

**I smoke every day**  **I am a former smoker**

Reason for today's visit: \_\_\_\_\_

Have you consulted other doctors regarding this problem?  Yes  No

If yes, please list: \_\_\_\_\_

Have you had any previous surgery for this problem?  Yes  No

If yes, when: \_\_\_\_\_

### PAST MEDICAL HISTORY

**General Health:**  Excellent  Good  Fair  Poor

Date of last physical examination: \_\_\_\_\_

Electrocardiogram performed?  Yes  No

Chest X-Ray?  Yes  No

Are you pregnant?  Yes  No

Do you currently wear a Pacemaker or ICD?  Yes  No

If yes, who is your Cardiologist: \_\_\_\_\_ Telephone: \_\_\_\_\_

**OTHER CURRENT MEDICAL PROBLEMS** (*Please list*): \_\_\_\_\_

\_\_\_\_\_

What is your daily or previous consumption of: Coffee/Tea: \_\_\_\_\_ Tobacco: \_\_\_\_\_ Alcohol: \_\_\_\_\_

Do you take Aspirin?  Yes  No Has this been prescribed by anyone?  Yes  No

If yes, by whom and how often do you take: \_\_\_\_\_

Do you take any: Tylenol, Bufferin, Anacin, Contac, Steroids, Cortisone?  Yes  No

If yes, how often: \_\_\_\_\_

### CURRENT MEDICATIONS

 (*Please list*)

Include dosages (including birth control pills, diuretics, blood pressure or heart medication, tranquilizers, hormones, blood thinners, sleeping pills or pain medications, over the counter medications, vitamins and herbal supplements)

\_\_\_\_\_  
\_\_\_\_\_

Do you have any allergies to any medications?  Yes  No

(*Please list*)

\_\_\_\_\_

Do you have any other allergies?  Yes  No

(*Please list*)

\_\_\_\_\_

Are you now, or have you ever, received psychiatric assistance?  Yes  No

If yes, please list name and address of psychiatrist or psychologist:

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**PREVIOUS SURGERY** *(Please list with dates)*

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Have you had complications from previous surgery?  Yes  No

If yes, please describe the complication:

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Has anyone in your family had complications from anesthesia?  Yes  No

Do you bruise easily?  Yes  No

**PREVIOUS ILLNESSES** *(Place an X after any illness you have had)*

Heart murmur___	Rheumatic fever___	Heart attack___
Heart disease___	High blood pressure___	Blood transfusion___
Pneumonia___	Pleurisy___	Emphysema___
Kidney trouble___	Bladder trouble___	Thyroid trouble___
Hiatal hernia___	Abnormal EKG___	Asthma___
Anemia___	Bleeding disorder___	Jaundice___
Hepatitis___	Ulcer___	Arthritis___
Diabetes___	Phlebitis___	Epilepsy___
Abnormal chest X-ray___	AIDS___	Venereal disease___
Tumor___	Cancer___	Stroke___
Nervous disorder___	Glaucoma___	Albuminuria___
Nerve deficit___	Kidney stones___	Tuberculosis___
Other_____		

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**PRESENT SYMPTOMS** *(Place an X after any symptoms you have now)*

Fever/chills___	Excess sweating___	Fatigue___
Vision problem___	Eye pain/redness___	Hearing trouble___
Nose bleeds___	Throat discomfort___	Cough___
Sputum___	Bloody sputum___	Wheezing___
Chest pains___	Heat intolerance___	Heart skipping___
Shortness of breath___	Swollen feet or ankles___	High blood pressure___
Jaundice___	Heartburn___	Difficulty swallowing___
Abdominal pain___	Nausea/vomiting___	Vomiting blood___
Black stools___	Rectal bleeding___	Diarrhea___
Acid indigestion___	Backache___	Arthritis___
Night time urine___	Bruise easily___	Bleed easily___
Increased thirst___	Increased urine___	Fainting___
Numbness___	Tremor___	Muscle___
Weakness___	Nervousness___	Depression___
Other: _____		