

Mammogram
Pap Smear
Bone Density Scan
Cholesterol

SIERRA VISTA HOSPITAL & CLINICS

800 East 9th Avenue, Truth or Consequences, NM 87901 Hospital: 575-894-2111 | Clinic: 575-894-3221

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Full name:	10 mm 1 m	
Date of birth:		

ADULT INTAKE FORM

		ADOLI	HAIVINE	Oltivi	
Allergies N	one				p i
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		7			
Medications and	Supplements [None	Dose		Times per day
Wicaldation	,				2.22.2.2%
		-			<u> </u>
		-	-		
		,			
		-			
Surgeries and Ho	spitalizations 🗆	None			
Туре		Date	e		Location/Facility
			77.		
Health Maintena	nce				
Test	Date		Facility/Pro	vider	Abnormal Result? Y or N
Colonoscopy					

Darcanal	Madical	Hictory	□None
Personal	ivieuicai	HISTOLA	LINOHE

✓ Disease/Condition	Date of diagnosis
Alcoholism/Drug use	
Asthma	
Cancer (type:)	2
Depression/Anxiety	
Suicidal/Bipolar	
Diabetes	
COPD	
Heart disease (heart attack, murmur, abnormal rhythm)	
High blood pressure	
High cholesterol	
Kidney disease	
Kidney stones	
Thyroid disease	
Migraine/headache	•
Stroke	
Anemia	
Stomach issues (ulcers, heartburn, etc.)	
Liver disease	
Seizures/Epilepsy	
Crohn's disease/Ulcerative Colitis	
Bleeding issues	
Prostate Issues	

Family Medic	cal His	story		None	\Box	Unkno	own								
Please check all that apply	Alcohol/drug use	Asthma	Cancer: (type)	СОРО	Depression/anxiety	Bipolar/suicidal	Diabetes	Early death	Heart disease	High blood pressure	Kidney disease	Stroke	Thyroid disease	Migraines	Autoimmune disease
Mother															
Father															
Brother															
Sister															
Child															
Maternal Grandmother															
Maternal Grandfather															
Paternal Grandmother							-						y 1614		
Paternal Grandfather															

Employer: Years of Education/highest Degree:	ocial History	
Marital status: Single Married Divorced Widowed Do you have children? YES NO If yes, how many: Do they live with you? YES NO Tobacco use? YES NO Cigarettes Cigars Vaping Chewing tobacco Answer if CURRENT USER How many per day? How many years? Are you interested in quitting? Do you drink alcohol? YES NO If yes, how many drinks per day? Do you use any recreational substances? YES NO Have you ever used needles to inject drugs? YES Are you sexually active? YES NO Birth control method: None Condom Pill Patch Ring Nexplanon UDD Do you exercise regularly? YES NO How long? How often? How many hours of sleep do you get on average? Other Providers/Specialists None	Occupation:	Retired Unemployed Disabled
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If yes, how many: Do they live with you? YES NO Tobacco use? YES NO	Marital status: Single Married Div	vorced Widowed
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Birth control method: None Condom Pill Patch Ring Nexplanon LIUD Do you exercise regularly? YES NO How long? How often? How many hours of sleep do you get on average? Other Providers/Specialists None	Do you use any recreational substances? YES	NO Have you ever used needles to inject drugs? YES NO
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Providers/Facility Specialty	Providers/Facility	Specialty

REVIEW OF SYSTEMS: PLEASE CHECK ALL THAT APPLY

CONSTITUTIONAL	✓ CARDIOVASCULAR	/	MUSCULOSKELETAL
Fever	Chest pain		Joint pain
Chills	Heart racing/palpitations		Joint swelling
Sweats	Heart fluttering		Leg pain with walking
Fatigue	Leg swelling		Muscle aches
Appetite Changes	1		Neck pain/neck stiffness
Weight Changes	GASTROINTESTINAL		Back pain
	Abdominal pain		Muscle weakness
ENT/Head/Eyes	Nausea/vomiting		
Change in vision	Constipation		NEUROLOGICAL
Ear pain	Diarrhea		Dizziness
Ear discharge	Acid reflux/heartburn		Lightheadedness
Hearing loss/ringing of ears	Blood in stool		Balance problems
Nosebleeds	Pain in rectum		Paralysis of any body part
Sinus pressure	7		Headaches
Sneezing	ENDOCRINE		Numbness/Tingling
Facial swelling	Hair changes		Seizures
Sinus congestion	Skin changes		Tremors
Mouth sores	Increase thirst		Weakness
Sore throat	Increased hunger	T	
Trouble swallowing	The state of the s		PSYCHIATRIC
Drooling	GENITOURINARY		Increase in stressors
The state of the s	Pain with urination		Behavior issues
RESPIRATORY	Urinary frequency		Confusion
Cough	Increased urinating at night		Depression
Shortness of breath	Blood in urine		Anxiety/Agitation
Wheezing	Painful periods		Decreased concentration
Sputum	Heavy periods		Hallucinations
Chest tightness	Irregular periods		Sleep disturbances
Choking	Menopause		Suicidal thoughts
Loud snoring	Testicular pain		
	Genital sores		OTHER ISSUES
HEMATOLOGICAL			
Easy bruising/bleeding	SKIN		
Swollen lymph nodes	Rashes		
	Ulcers/wounds		
	Changing mole	71.5	