



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

erica.santome@lpnt.net

Full name: _____

Date of birth: _____

ADULT INTAKE FORM

Allergies None

Allergy	Reaction

Medications and Supplements None

Medication/Supplement	Dose	Times per day

Surgeries and Hospitalizations None

Type	Date	Location/Facility

Health Maintenance

Test	Date	Facility/Provider	Abnormal Result? Y or N
Colonoscopy			
Mammogram			
Pap Smear			
Bone Density Scan			
Cholesterol			

Social History

Occupation: <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled	
Employer:	Years of Education/highest Degree:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Do you have children? YES NO If yes, how many: Do they live with you? YES NO	
Tobacco use? YES NO <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Vaping <input type="checkbox"/> Chewing tobacco	
<u>Answer if CURRENT USER</u>	<u>Answer if FORMER USER</u>
How many per day? How many years? Are you interested in quitting?	Quit date: How many per day? How many years?
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 NO	
Are you sexually active? YES NO Birth control method: <input type="checkbox"/> None <input type="checkbox"/> Condom <input type="checkbox"/> Pill <input type="checkbox"/> Patch <input type="checkbox"/> Ring <input type="checkbox"/> Nexplanon <input type="checkbox"/> IUD	
Do you exercise regularly? YES NO How long? How often?	
How many hours of sleep do you get on average?	How would you rate your diet? <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor

Other Providers/Specialists None

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				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				Headaches
	Sneezing		ENDOCRINE		Numbness/Tingling
	Facial swelling		Hair changes		Seizures
	Sinus congestion		Skin changes		Tremors
	Mouth sores		Increase thirst		Weakness
	Sore throat		Increased hunger		
	Trouble swallowing				PSYCHIATRIC
	Drooling		GENITOURINARY		Increase in stressors
			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		