CROWN
Clinical Records
On-Line Web Network
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CROWN Adult Intake Form Section 1

Name_____ Date of Birth_____ Today's Date_____
(First Last)

Referring Physician Name & Address_____

Primary Care Physician (if different)_____ Preferred Pharmacy_____

Pharmacy Phone_____ Pharmacy Address_____

What is the reason for your visit today?_____

Customize questions below for your practice specialty: Note HPI factors for documentation: ***location,quality,severity, duration, timing, context, modifying factors, associated signs and symptoms***

Is this problem a result of a work-related injury?_____ If yes, what was the date of the injury?_____

Describe the problem_____ Where is it?_____ What does it feel like?_____

Problem causes pain/discomfort? Yes__ No__ When does it occur?_____ How long does it last?_____

Indicate pain severity on chart: 0 No Pain 1 2 3 4 5 Moderate 6 7 8 9 10 Worst Possible

Does it move?_____ What makes it better or worse?_____

Additional symptoms?_____

Do you have any allergies to medications or other substances? Yes__ No__ If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis)._____

_____

Please list ALL of your current medications below (use back of page if you need more room)

Medication Name	Dose	When do you take it?	Approximate start date of medication

MEDICAL HISTORY: HAVE YOU EVER HAD (been diagnosed or treated for) ANY OF THE FOLLOWING (if yes, describe):
Note: use your own questions here – let us know what you choose so we can set up keywords in CROWN

Heart Disorder Yes__ No__ _____

Cancer Yes__ No__ _____

Diabetes Yes__ No__ _____

Blood Pressure Disorder Yes__ No__ _____

Thyroid Disorder Yes__ No__ _____

Lung Disorder Yes__No__ _____

Stomach/Intestinal Disorder Yes__No__ _____

Skin Disorder Yes__No__ _____

MEDICAL HISTORY Continued:

Clotting Disorder Yes__No__ _____

Eye Disorder Yes__No__ _____

Psychiatric Disorder Yes__No__ _____

Urinary/Kidney Disorder Yes__No__ _____

Liver Disorder Yes__No__ _____

Orthopedic Disorder Yes__No__ _____

Cholesterol Disorder Yes__No__ _____

Neurologic Disorder Yes__No__ _____

Other Yes__No__

FAMILY HISTORY: *Please indicate any major conditions/illnesses that your family members have had:*

RELATIVE CONDITION & DESCRIPTION LIVING (Y/N) IF DECEASED, AT WHAT AGE?

Mother:_____

Father:_____

Other:_____

SURGICAL HISTORY: List any surgeries you have had and the approximate date:

_____

_____

Have you had a blood transfusion Yes__No____? If yes, when?_____

SOCIAL HISTORY:

Occupation: _____Marital Status:_____Children? Yes__No__ Their ages? __

Do you exercise regularly? Yes__No__ Describe your exercise routine:_____

Do you have pets in your home?Yes__No__ Describe:_____Health Care Proxy_____

Smoking. Currently? Yes__No__ Previously? Yes__No__ Years Smoked_____ Packs per day_____

Other tobacco or substance_____Date stopped_____

Are/were you exposed to 2nd hand smoke at home or work? Yes__No__ , If "Yes," explain_____

Other substances: Alcohol? Yes__No__ Recreational Drugs? Yes__No__

Describe use_____

Patient Signature_____**Date**_____

FOR OFFICE USE ONLY: *CROWN-6-28-09 intake*

The following sections were entered into CROWN by (sign initials next to the section(s) you entered):

*All*_____*Problems*_____*Allergies*_____*Medical Hx*_____

Surgical Hx _____*Family Hx*_____*Social History*_____

Physician Signature_____**Date**_____