Name_____ **DOB**_____

Address_____

_____

Cell phone_____

Secondary number _____

Email address

_____

David S. Coykendall, D.O.
3370 Burns Road, Suite 100
Palm Beach Gardens, FL 33410
(561) 513-9806 p / (561) 727-8805 f

Intake forms

What is your chief complaint?_____

Duration

_____**location**_____

Severity (please circle) MILD MODERATE SEVERE

Associated symptoms (circle all that apply)

NAUSEA VOMITING FEVER CHEST PAIN SHORTNESS OF BREATH

Past medical and surgical history:

_____

_____

_____

_____

_____

Current medications:

_____

_____

_____

Allergies:

_____

_____

Family history:

_____

_____

Current social history:

1- Alcohol use: yes no

2- Nicotine: yes no

If yes, current former (within 1 year) distant (greater than 1 year)

Type: smoking e-cigarette chewing patch gum

3- Type of employment: no employment desk based labor light physical labor

Moderate physical labor heavy physical labor

4- Sporting: none sporadic (1x month) moderate (1x week)

Intense (greater than 1x week)

Please check YES to any of the following that apply to you.

REVIEW OF SYSTEMS

	YES	NO
Constitutional Symptoms		
Night sweats, fevers		
Fatigue/tiredness		
Appearance: normal		
Abnormal		
EYES		
Corrective lenses/contacts		
Blurred vision		
Glaucoma		
EAR, NOSE, MOUTH & THROAT		
Hearing loss/ringing in ears		
Sore throat		
Sensation of lump in the throat		
RESPIRATORY		
Cough		
Asthma		
CARDIOVASCULAR		
High blood pressure		
Arrhythmia		
Phlebitis		
Heart problems		
Murmur		
GASTROINTESTINAL		
Abdominal pain		
Vomiting		
Heartburn		
Reflux		
Bowel incontinence		
Swallowing difficulty		
GENITOURINARY/UROLOGY		
Blood in the urine		
Excessive night time urination		
Urine hesitancy		
Kidney stones		
Sexual problems		
Weak urine stream		
MUSCULOSKELETAL		
Arthritis		
Muscle pain		
Joint pain or swelling		

	YES	NO
Good general health		
Recent weight changes		

Comments: _____

Changes in vision		
Double vision		

COMMENTS: _____

Nose bleeds		
Swollen glands in neck		
Sinus problems		

COMMENTS: _____

Shortness of breath		

COMMENTS: _____

Pedal edema		
Heart attack		
PND		
Chest pain or discomfort		
Unable to walk up one flight of steps		

COMMENTS: _____

Nausea		
Diarrhea		
Indigestion		
Change in bowel habits		
Constipation		

COMMENTS: _____

Painful urination		
Daytime urinary frequency		
Force of stream		
Menstrual problems		
Testicle pain		

COMMENTS: _____

Back pain or injuries		
Claudication		
Numbness or tingling sensation		

COMMENTS _____

Please check YES to any of the following that apply to you.

	YES	NO
NEUROLOGIC		
Weakness	___	___
Seizure	___	___
Headaches	___	___
Dizziness	___	___
Numbness	___	___
Head injury	___	___
Stroke	___	___
Paralysis or tremors	___	___

COMMENTS: _____

PSYCHIATRIC		
Difficulty sleeping	___	___
Depression	___	___
Manic episodes	___	___
Schizophrenia	___	___

COMMENTS _____

HEMATOLOGIC/LYMPHATIC		
Anemia	___	___
Slow to heal after cuts	___	___
Easy bruising/bleeding	___	___
Enlarge glands	___	___

COMMENTS _____

ENDOCRINE		
Thyroid disease	___	___
Heat/cold intolerance	___	___
Excessive thirst	___	___
Diabetes	___	___
Excessive urination	___	___
Changes in hair	___	___

COMMENTS _____

INTEGUMENTARY		
Breast pain or discharge	___	___
Change in skin color	___	___
Rashes	___	___
Change in hair/nails	___	___
Itching	___	___
Varicose veins	___	___

COMMENTS _____

Consent to treat and financial agreement

I consent to treatment, diagnostic, and or therapeutic treatment from Dr. David Coykendall. I agree to pay all copays, deductibles, and other charges before the date of surgery. I authorize payments directly to Dr. Coykendall of all such insurance benefits payable to me. I authorize the doctor to release medical information to such insurance companies as is necessary to receive payment for services rendered.

I understand that Dr. Coykendall and his staff may need to use and disclose information about my health or medical problems for the purpose of arranging, conducting, or referring treatments, for obtaining payments for services rendered to me and for the operations of the practice. I consent to the use of my information for the purposes of treatment, payment, and healthcare operations.

Printed name _____

Signature_____/Date_____