Laurie C. Nash, M.D.
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New York, NY 10021
212 486-5380

New Patient Intake Form

Date: ________________________

Demographic Information

Gender Identity: _______

Name: ____ Date of Birth: __________ Age: __________

Reason for visit – Why are you being seen by Dr Nash today? Briefly describe the problem you are having or what you would like to discuss with Dr Nash.

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Surgical History: Please list all operations you have had: Date:

____ ____________

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Medical and Psychiatric History: Please list all active conditions Duration

____ ____________

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____ ____________

Please list all **MEDICATIONS** you take routinely, prescribed or over the counter, including dosages:

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Please **LIST** all allergies and sensitivities (e.g. medications, foods, latex, iodine, etc.)

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Social History

Occupation: ____ Currently employed: ☐ yes ☐ no

Do you smoke cigarettes? ____________________ If so, how many packs a day? _______________________

Are you a former smoker? ____________________ If so, how long ago did you quit? ____________________

Do you drink alcohol? _______________________ If yes, how much daily? __________________________

Do you use recreational drugs? ________________ Type? ____

Sexual History/Sexual Preference:

___

___

Are there any problems in your sex life you wish to discuss?

___

Family History Do you have a family member affected with the following? If yes, at what age?

Condition	Yes	No	Age	Relationship
Colon Cancer	___	___	_____	_________________
Dementia	___	___	_____	_________________
Diabetes	___	___	_____	_________________
Breast Cancer	___	___	_____	_________________
Hypertension	___	___	_____	_________________
Migraines	___	___	_____	_________________
Ovarian Cancer	___	___	_____	_________________
Uterine Cancer	___	___	_____	_________________
Melanoma	___	___	_____	_________________
Parkinson's	___	___	_____	_________________
Seizures	___	___	_____	_________________
Prostate Cancer	___	___	_____	_________________
Heart Attack	_____	_____	_____	_________________
Stroke	_____	_____	_____	__________________
High Cholesterol	_____	_____	_____	___________________

Other____

____

Any other medical information you would like to provide:

____

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____

Patient Signature Date completed

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Review of Systems: Do you currently, or have you had a problem with any of the following:

Constitutional:	**Circle**	**One**	***Genitourinary***:	**Circle**	**One**
Fever	Yes	No	Painful urination	Yes	No
Weight loss >5 lbs	Yes	No	Blood in your urine	Yes	No
Excessive fatigue	Yes	No	Difficult starting/stopping stream	Yes	No
History of Falls	Yes	No	Incontinence	Yes	No
Eye			***Musculoskeletal***:		
Glaucoma	Yes	No	Arm or leg weakness	Yes	No
			Arm or leg pain	Yes	No
Ear, Nose, Throat & Mouth:			Joint pain or swelling	Yes	No
Hearing loss	Yes	No			
Ringing in ears	Yes	No	***Integumentary***:		
Inability to smell	Yes	No	Breast pain, tenderness	Yes	No
Balance (vertigo, spinning, etc.)	Yes	No	Nipple discharge	Yes	No
			Unusual moles	Yes	No
Cardiovascular:					
Chest pain or angina	Yes	No	***Neurological***:		
Irregular pulse	Yes	No	Fainting spells or “black outs”	Yes	No
Swelling in hands or feet	Yes	No	Headaches	Yes	No
Leg pain while walking	Yes	No	Problems with memory	Yes	No
			Disorientation	Yes	No
Respiratory:			Difficulty with speech	Yes	No
Shortness of breath	Yes	No	Inability to concentrate	Yes	No
Bloody sputum	Yes	No	Double or blurred vision	Yes	No
			Weakness in arms and/or legs	Yes	No
Gastrointestinal:			Loss of sensation	Yes	No
Nausea	Yes	No	Difficulty with balance	Yes	No
Vomiting	Yes	No			
Abdominal pain	Yes	No	***Psychiatric***:		
Change in bowel habits	Yes	N	Anxiety	Yes	No
			Depression	Yes	No
Endocrine:					
Excessive thirst/urination	Yes		***Hematologic/Lymphatic***:		
			Persistent swollen glands/lymph nodes	Yes	No

Date of most recent screening examinations or tests:

Ophthalmology: _____________ Dermatology: _______________ Gynecology: __________________

Bone Density: _____________ Mammography: _____________ PAP: _________________________

Colonoscopy: ________________ Upper Endoscopy: _____________ Dentist: _______________________

Other Specialists you see:____

Date of last immunizations/vaccines:

Tetanus: ___________ Influenza: ___________ Pneumonia/PCV 20, PCV 13/Pneumovax 23: ________________

Shingles: #1 ___________#2____________

Covid Vaccines Type and Dates: ____

Covid Booster Type and Dates: ____

Please use this space for anything additional you would like to discuss: