

Please return form to:  
Dr. Matthew Perchemlides  
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Tulsa, OK 74135

**New Patient Intake Form:**

Today's Date:

Name:

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Mailing Address:

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Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone number: \_\_\_\_\_ Indicate if it is okay to leave a message at this number  
(Yes/No)

Email (only if you would like communication at this email address)

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Emergency Contact person \_\_\_\_\_

Emergency Contact phone number \_\_\_\_\_

Please list your chief concerns in the order of their importance to you.

Chief Concern 1: \_\_\_\_\_

Rate severity (minor) 1..2..3..4..5..6..7..8..9..10 (severe)

When did this begin?

What makes this worse?

What helps this?

What other care have you received for this concern?

Chief Concern 2: \_\_\_\_\_

Rate severity (minor) 1..2..3..4..5..6..7..8..9..10 (severe)

When did this begin?

What makes this worse?

What helps this?

What other care have you received for this concern?

Chief Concern 3: \_\_\_\_\_

Rate severity (minor) 1..2..3..4..5..6..7..8..9..10 (severe)

When did this begin?

What makes this worse?

What helps this?

What other care have you received for this concern?

Chief Concern 4: \_\_\_\_\_

Rate severity (minor) 1..2..3..4..5..6..7..8..9..10 (severe)

When did this begin?

What makes this worse?

What helps this?

What other care have you received for this concern?

Chief Concern 5: \_\_\_\_\_

Rate severity (minor) 1..2..3..4..5..6..7..8..9..10 (severe)

When did this begin?

What makes this worse?

What helps this?

What other care have you received for this concern?

*Other Current Diagnoses:*

1.

\_\_\_\_\_

2.

\_\_\_\_\_

3.

\_\_\_\_\_

4.

\_\_\_\_\_

Past Surgical History:

1. \_\_\_\_\_ Year \_\_\_\_\_

2. \_\_\_\_\_ Year \_\_\_\_\_

3. \_\_\_\_\_ Year \_\_\_\_\_

4. \_\_\_\_\_ Year \_\_\_\_\_

History of past traumatic injuries (broken bones, motor vehicle accident, etc.):

1. \_\_\_\_\_ Year \_\_\_\_\_

2. \_\_\_\_\_ Year \_\_\_\_\_

3. \_\_\_\_\_ Year \_\_\_\_\_

4. \_\_\_\_\_ Year \_\_\_\_\_

Family History of Illness:

Siblings: \_\_\_\_\_

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Mother's parents: \_\_\_\_\_

Father's parents: \_\_\_\_\_

Substances:

Tobacco use

Cigarettes: packs per day \_\_\_\_\_ number of years smoking \_\_\_\_\_ Date Quit \_\_\_\_\_

Chewing tobacco: amount daily \_\_\_\_\_ number of years chewing \_\_\_\_\_ Date Quit \_\_\_\_\_

Other \_\_\_\_\_

Allergies:

Medication:

1 \_\_\_\_\_ Reaction \_\_\_\_\_

2 \_\_\_\_\_ Reaction \_\_\_\_\_

3 \_\_\_\_\_ Reaction \_\_\_\_\_

Foods:

1 \_\_\_\_\_ Reaction \_\_\_\_\_

2 \_\_\_\_\_ Reaction \_\_\_\_\_

3 \_\_\_\_\_ Reaction \_\_\_\_\_

Environmental:

1 \_\_\_\_\_ Reaction \_\_\_\_\_

2 \_\_\_\_\_ Reaction \_\_\_\_\_

3 \_\_\_\_\_ Reaction \_\_\_\_\_

Medications currently prescribed:

1 \_\_\_\_\_ Dosage \_\_\_\_\_ Reason \_\_\_\_\_

2 \_\_\_\_\_ Dosage \_\_\_\_\_ Reason \_\_\_\_\_

3 \_\_\_\_\_ Dosage \_\_\_\_\_ Reason \_\_\_\_\_

4 \_\_\_\_\_ Dosage \_\_\_\_\_ Reason \_\_\_\_\_

5 \_\_\_\_\_ Dosage \_\_\_\_\_ Reason \_\_\_\_\_

Over the counter medicine currently or frequently taking:

1 \_\_\_\_\_ Dosage \_\_\_\_\_ Reason \_\_\_\_\_

2 \_\_\_\_\_ Dosage \_\_\_\_\_ Reason \_\_\_\_\_

3 \_\_\_\_\_ Dosage \_\_\_\_\_ Reason \_\_\_\_\_

4 \_\_\_\_\_ Dosage \_\_\_\_\_ Reason \_\_\_\_\_

5 \_\_\_\_\_ Dosage \_\_\_\_\_ Reason \_\_\_\_\_

6 \_\_\_\_\_ Dosage \_\_\_\_\_ Reason \_\_\_\_\_

Supplements:

1 \_\_\_\_\_ Dosage \_\_\_\_\_ Reason \_\_\_\_\_

2 \_\_\_\_\_ Dosage \_\_\_\_\_ Reason \_\_\_\_\_

3 \_\_\_\_\_ Dosage \_\_\_\_\_ Reason \_\_\_\_\_

4 \_\_\_\_\_ Dosage \_\_\_\_\_ Reason \_\_\_\_\_

5 \_\_\_\_\_ Dosage \_\_\_\_\_ Reason \_\_\_\_\_

6 \_\_\_\_\_ Dosage \_\_\_\_\_ Reason \_\_\_\_\_

Any regular exercise routine:

Type \_\_\_\_\_ Duration (minutes per day) \_\_\_\_\_ Frequency \_\_\_\_\_

Type \_\_\_\_\_ Duration (minutes per day) \_\_\_\_\_ Frequency \_\_\_\_\_

List all food and all beverages you have had in the last 24 hours.

Breakfast \_\_\_\_\_

Snack \_\_\_\_\_

Lunch \_\_\_\_\_

Snack \_\_\_\_\_

Dinner \_\_\_\_\_

Water: \_\_\_\_\_

Coffee/Tea \_\_\_\_\_

Soda \_\_\_\_\_

Current Height \_\_\_\_ feet \_\_\_\_ inches

Current Weight \_\_\_\_ feet \_\_\_\_ inches

Fatigue (minor)1..2..3..4..5..6..7..8..9..10(severe).

Sleep Problems (minor)1..2..3..4..5..6..7..8..9..10 (severe)

Emotional Stress (minor)1..2..3..4..5..6..7..8..9..10 (severe)

Physical Stress (minor)1..2..3..4..5..6..7..8..9..10 (severe)

**SOCIOECONOMICS:**

Occupation: \_\_\_\_\_

Education completed: \_ Grade school \_ High school  
\_ College \_ Graduate school \_\_\_ Post grad

Years of education \_\_\_\_\_

Marital status: \_ Single \_ M \_ Sep \_ D \_ W \_ Co-habiting  
\_ Engaged... \_ Other: \_\_\_\_\_

Spouse/Partner's name: \_\_\_\_\_

Number of children: \_\_\_\_\_

Who lives at home with you? \_\_\_\_\_

*Circle all that apply to you, either now or in the past:*

**Neurological:**

Declining memory  
Dizziness  
Foggy thinking  
Headaches  
History of head injury  
History of stroke  
History of TIA  
Light sensitivity  
Loss of balance  
Loss of sensation (touch)  
Migraines  
Peripheral neuropathy  
Problems with mental focus  
Seizures  
Tremors  
Weakness  
Other \_\_\_\_\_

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**Mental/Emotional:**

Anorexia  
Anxiety  
Bulimia  
Confusion  
Depressed mood  
Emotional fluctuations  
History of Trauma  
Restlessness  
Suicidal action  
Suicidal thoughts  
Other \_\_\_\_\_

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**Eyes, Ears, Nose, Throat:**

blurry vision  
cataracts  
cold or canker sore  
congestion  
dark circles  
dental problems  
difficulty hearing  
difficulty swallowing  
dizziness  
double vision  
dryness of eyes, throat, etc.  
earaches

eye pain/red eye  
fainting/blackouts  
frequent colds/infections  
glasses/contacts  
glaucoma  
grinding teeth  
hair loss  
hayfever  
head injury  
headaches  
hoarse voice  
loss of smell  
neck lumps/swelling  
neck pain  
nosebleeds  
puffy eyes  
ringing in ears  
sensitive to light  
sinus problems  
sore throat  
sore tongue  
sore/bleeding gums  
tearing

**Respiratory:**

asthma  
bronchitis  
chest colds  
chest pain  
chest pain  
cough up blood  
coughing  
coughing sputum  
emphysema  
heart palpitations  
high blood pressure  
pneumonia  
shortness of breath  
swollen ankles  
wheezing

**Cardiac:**

Activity intolerance  
Aneurysm  
Angina  
Bacterial endocarditis  
Congenital heart defect

High blood pressure  
High cholesterol  
History chest pain  
History heart attack  
Irregular heart beat  
Leg pain with activity  
Pacer  
Valve problem

**Gastrointestinal**

blood in stool  
blood in vomit  
constipation  
diarrhea  
difficult swallowing  
excessive appetite  
gas/bloating  
hemorrhoids  
indigestion  
light colored stool  
loss of appetite  
mucous in stool  
nausea  
rectal pain/itching  
stomach pain  
undigested food in stool  
vomiting  
yellow eyes or skin

**Genitourinary**

bladder infections  
blood in urine  
genital discharge  
change in urine color  
difficulty urinating  
frequent urination  
genital sores  
incontinence  
kidney stones  
odorous urine  
pain with urination  
sexual difficulty  
STDs  
urge to urinate

**Musculoskeletal**

aching muscles

Areas of tenderness  
Cramps  
discomfort at joints  
numbness/tingling  
restless legs  
swollen joints  
weakness

**Skin**

acne  
boils  
color change  
easy bruising  
fungus  
hives  
itching  
lesions  
lumps  
moles  
rashes  
warts

**Endocrine**

Always cold  
Always hot  
Chronic Fatigue  
Increased/decreased hunger  
Increased/decreased thirst  
Thyroid problem

**Blood, Immune**

Autoimmune disease  
Bruising  
Frequent bleeding  
Frequent Flu/Colds  
Painful lymph nodes  
Slow wound healing  
Swollen glands

**Male Reproductive**

Discharge  
Erection difficulty  
Hernias  
Infertility  
Painful erections  
Painful testicles  
Painful urination  
Premature ejaculation  
Prostate problems  
Sexual difficulties  
Swelling in testicles  
Testicular masses

**Female Reproductive**

# of live births \_\_\_\_\_  
# of pregnancies \_\_\_\_\_  
# of spontaneous or missed miscarriages \_\_\_\_\_  
body hair  
breast pain  
difficulty conceiving  
facial hair  
genital eruptions  
heavy periods  
lack of sexual desire  
lumps in breast(s)  
missed periods  
nipple discharge  
orgasm difficulty  
pain with intercourse  
painful menses  
pelvic pain  
PMS  
spotting  
STDs  
use of birth control  
vaginal discharge  
vaginal dryness  
vaginal itching  
vaginal burning  
yeast infections

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