David A. Gentile, DO, ABAARM, ABIHM
Board Certified Diplomate Physician

Main Office
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(t) 631.821.4200
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www.oasismedicine.com

NEW PATIENT INTAKE FORM

Name: _____ **Date of Initial Consultation:** _____

Date of Birth: _____ **Age:** _____ **Referred by:** _____

Home #: _____ **Cell #:**_____ **Other #:** _____

E-Mail: _____ **Preferred Contact:** _____

Patient History

HEIGHT: _____ **WEIGHT:** _____ **LOST/GAINED IN PAST 6MONTHS:** _____

Chief Complaint: _____

_____

_____

_____

Past Medical History: _____

_____

_____

_____

Past Surgical History with Dates, if possible: _____

_____

_____

_____

Prescription Medications with Dosages: _____

_____

_____

_____

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Vitamins, Supplements, Over-the-Counter Medication: _____

_____

_____

_____

Medication Allergies and Other Allergies: _____

_____

_____

_____

Date of Last Physical Exam:

_____

Most Recent Bloodwork, Dates, and Location:

_____

_____

Recent Radiology Imaging, Dates, and Location:

_____

_____

_____

Last OB/GYN Exam, Mammogram, Etc. (If Applicable): _____

_____

Any Recent Infections, Illnesses, Injuries, Etc.: _____

_____

_____

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Family Medical History: _____

Current and Former Social History (smoking/alcohol/recreational drug use, etc.):

Occupation, Job Description: _____

Activities, Hobbies, Sports, Etc.:

Dietary Habits: _____

Overall Stress Level (Home, Work, School, etc.): _____

Quality of Sleep, Ability to Sleep, etc.:

History of Depression, Anxiety, PTSD, Brain Fog, etc.:

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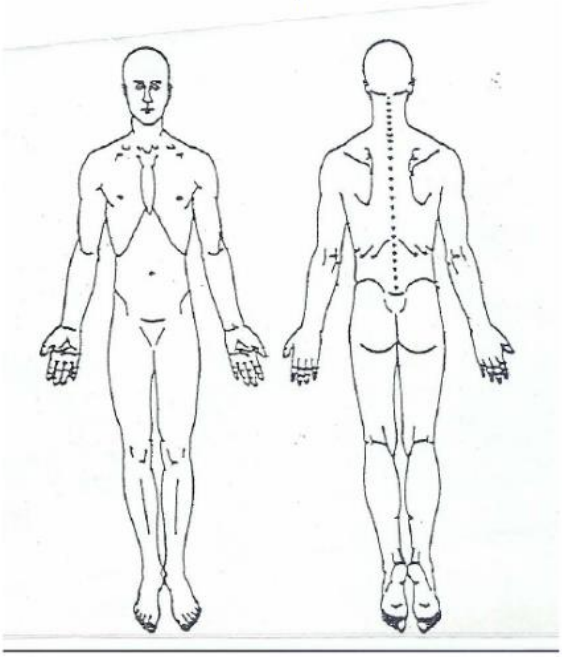
Pain History (if applicable)

Please indicate the Location of your Pain:

KEY:
Pins and Needles = 000000 Stabbing = //////
Burning = xxxxxx Deep Ache = zzzzzz



Please rate your current level of pain on the following scale (check one):

0 (no pain) 1 2 3 4 5 6 7 8 9 10 (worst imaginable pain)

Please rate your worst level of pain in the last 24 hours on the following scale (check one):

0 (no pain) 1 2 3 4 5 6 7 8 9 10 (worst imaginable pain)

Please rate your best level of pain in the last 24 hours on the following scale (check one):

0 (no pain) 1 2 3 4 5 6 7 8 9 10 (worst imaginable pain)

Nature and Severity of Pain:

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Onset of Pain, Duration of Pain:

Pattern of Radiating Pain:

Numbness, Tingling, Weakness, Poor Balance, Changes in Bladder or Bowel Function, Other Associated Symptoms:

What increases the pain? :

What improves the pain? :

Hours per day spent sitting, driving, on computer? :

Any possible or known cause of the pain? :

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Traumatic History (Motor vehicle accidents, work-related accidents, falls, etc.), with Dates: _____

_____

_____

_____

Is this related to a No-Fault Case or Worker's Compensation Case? If so, please briefly explain:

_____

_____

_____

Other Providers you have seen regarding this issue? (Include specialty, Dates seen, Imaging done, Treatment, etc.):

_____

_____

_____

_____

_____

_____

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General Comments, Concerns, etc.? : _____

_____

_____

_____

Please check any of the following symptoms that you may have currently or within the last year:

- ☐ Headache
- ☐ Dizziness/Fainting
- ☐ Eye pain
- ☐ Ear pain
- ☐ Hearing Loss
- ☐ Vision Loss
- ☐ Nose Bleeds
- ☐ Nasal Discharge
- ☐ Nasal Pain
- ☐ Throat Pain
- ☐ Cough
- ☐ Wheezing
- ☐ Sputum Production
- ☐ Urinary Urgency
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Recurrent UTI
- ☐ Shortness of Breath
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloody/Black Stools
- ☐ Acid Reflux
- ☐ Rashes
- ☐ Lesions
- ☐ Itching
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Loss of Appetite
- ☐ Leg Swelling
- ☐ Easily Bruised
- ☐ Bleeding Tendencies (Clots or Easy Bleeding)
- ☐ Muscle Weakness
- ☐ Sexual Dysfunction
- ☐ General Fatigue
- ☐ Insomnia
- ☐ Depression
- ☐ Anxiety
- ☐ PTSD
- ☐ Brain Fog
- ☐ Poor Concentration
- ☐ Breast Tenderness
- ☐ Breast Lumps
- ☐ Breast Discharge
- ☐ AIDS/HIV Positive
- ☐ Hepatitis
- ☐ MRSA Positive

Female Patients:

- ☐ Date of Last Menses: _____
- ☐ Irregular Menses

Please use additional paper if you need to add anything else or run out of room on any section.

WHEN YOU COME TO YOUR FIRST APPOINTMENT PLEASE BRING ANY LAB, RADIOLOGY, CONSULTATION REPORTS OR RESULTS YOU WOULD LIKE TO SHARE WITH DR. GENTILE

Signature:_____ **Date:**_____