1111 Medical Center Blvd, SuiteN502
Marrero, LA 70072
504-934-8424

Intake Form

Demographic Information

Name: ____ Date of Completion: _______ / _______ / __________

Date of Birth: _______ / _______ / __________ Age: ___________ Sex: ☐ Male ☐ Female

Race: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander ☐ Other, Specify: _____________________________

Marital Status: ________________ Highest Level of Education: __________ Occupation: ______________________

Patient Contact Information

Street Address: ____

City: _______________________________________ State: _______________ Zip Code: ________________________

Home Phone: ____________________________________ Cell Phone: ______________________________________

Email Address: ____

What is the best time of Day to Contact You? ____

Emergency Contact

Primary Emergency Contact Name: ___________________________________ Phone: _________________________

Secondary Emergency Contact Name: _________________________________ Phone: _________________________

Primary Care Physician Information

Primary Care Physician or Office Name: ____

Street Address: ____

City: ____ State: ____________ Zip Code: _____________________

Office Number: ____________________________________ Fax Number: ____________________________________

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Tobacco History

Have you ever Smoke Tobacco Products? ☐ Yes ☐ No

Type of Tobacco Product(s): ____

If Yes, Amount per Day: ____________________ # of Years Smoked: ____________________

Are you still smoking? ☐ Yes ☐ No If no, when did you quit? ____________________

Alcohol History

Have you ever consumed alcohol? ☐ Yes ☐ No

Type of Alcohol: ____

If Yes, Amount Consumed per Day: ____________________ # of Years Consumed: ____________________

Are you still consuming alcohol? ☐ Yes ☐ No If no, when did you quit? ____________________

Allergies

☐ **None**

Food/Drug Allergy	Start Date	Reaction
	☐ Birth or ☐ Onset Date: _________	
	☐ Birth or ☐ Onset Date: _________	
	☐ Birth or ☐ Onset Date: _________	
	☐ Birth or ☐ Onset Date: _________	

Family History

Diagnosis	Family Member(s)
Heart Disease / Heart Attack	
Diabetes Type I or II	
Asthma	
Dementia	

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Review of Body Systems		
Please indicate if you have any of the following:		
Eyes	**Start Date**	**Stop Date or Ongoing**
☐ Cataracts ☐ Right ☐ Left	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Macular Degeneration	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Glaucoma	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Diabetic Retinopathy	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
Ear, Nose, and Throat	**Start Date**	**Stop Date or Ongoing**
☐ Seasonal Allergies or Allergic Rhinitis	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Impaired Hearing	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Chronic Sinusitis	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
Respiratory	**Start Date**	**Stop Date or Ongoing**
☐ Asthma	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Chronic Bronchitis	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ COPD	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Emphysema	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Chronic Pneumonia	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Sleep Apnea ☐ Use CPAP	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Tuberculosis	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
Cardiovascular	**Start Date**	**Stop Date or Ongoing**
☐ Angina (Chest Pain)	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Heart Murmur	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Heart Attack	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Irregular Heart Beat (Atrial Fibrillation)	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ High Blood Pressure	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ High Cholesterol / Lipids	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Coronary Artery Disease	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Congestive Heart Failure	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Peripheral Vascular Disease	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing

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Gastrointestinal	Start Date	Stop Date or Ongoing
☐ Acid Reflux / GERD	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Ulcers	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Hernia Type:_________________	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Gastric Polyps	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Hemorrhoids	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Diverticulitis	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Irritable Bowel Syndrome	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Non-Alcoholic Fatty Liver	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Chronic Constipation	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Chronic Diarrhea	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Gallstones	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
Endocrine / Metabolic	**Start Date**	**Stop Date or Ongoing**
☐ Diabetes Mellitus Type: ___________________	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Hypoglycemia (Low Blood Sugar)	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Hyperthyroidism (Overactive)	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Hypothyroidism (Underactive)	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Thyroid Nodule	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Gout	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Vitamin Deficiency Type: _____________________	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
Hematologic	**Start Date**	**Stop Date or Ongoing**
☐ Clotting Disorder	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Chronic Anemia	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
Immunologic	**Start Date**	**Stop Date or Ongoing**
☐ HIV/AIDS	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Lupus	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Cancer Type: _____________________	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing

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Hepatic	Start Date	Stop Date or Ongoing
☐ Liver Disease	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Hepatitis A, B, or C Type: ____________________	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
Renal	**Start Date**	**Stop Date or Ongoing**
☐ Kidney Stones	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Recurrent Kidney Infections	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Chronic Kidney Disease	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
Urogenital / Gynecologic	**Start Date**	**Stop Date or Ongoing**
☐ Overactive Bladder	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Uterine Fibroids	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Uterine Cysts	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Endometriosis	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Erectile Dysfunction	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Benign Prostate Hypoplasia (BPH)	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing

Males Method of Contraception: ☐ NA, Female
☐ Vasectomy ☐ Condoms/Spermicide ☐ Abstinence ☐ Sterile Partner ☐ None ☐ Other: ________________

Females Reproductive History: ☐ NA, Male
Are you currently Pregnant, Lactating, or Breast Feeding? ☐ Yes ☐ No

Please specify: # of pregnancies: ______ # of Live Births: _______
# of C-Sections: ______ with dates: _____ / _____ / ________, _____ / _____ / _________

Check all reproductive procedures you have received:
☐ Bilateral Tubal Ligation, Date: ____ / ____ / _______ ☐ Partial Hysterectomy, Date: ____ / ____ / _______
☐ Complete Hysterectomy, Date: ____ / ____ / _______ ☐ Bilateral Oophorectomy, Date: ____ / ____ / _______
☐ Uterine Ablation, Date: ____ / ____ / _______ ☐ IUD Placement, Date: ____ / ____ / _______
☐ Contraceptive Implant Placement, Date: ____ / ____ / _________

When was your last Menstrual Period? _____ / _____ / ________
If no longer having Menstrual Periods, was this Spontaneous or due to a procedure? ☐ Spontaneous ☐ Procedure

Current Method of Contraception:
☐ Surgically Sterile ☐ Postmenopausal ☐ Oral Contraceptives ☐ Transdermal Patch Contraceptive ☐ IUD
☐ Contraceptive Implant ☐ Condoms/Spermicide ☐ Abstinence ☐ Sterile Partner ☐ None
☐ Other: _____________________

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Musculoskeletal	Start Date	Stop Date or Ongoing
☐ Broken Bones Location: ___________________	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Osteoarthritis Location: ___________________	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Rheumatoid Arthritis	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Fibromyalgia	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Neck/Back Pain Reason: ____________________	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Shoulder Pain Reason: ____________________	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Hip Pain Reason: ____________________	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Knee Pain Reason: ____________________	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
Psychiatric	**Start Date**	**Stop Date or Ongoing**
☐ Anxiety or Panic Attacks	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Depression	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Bipolar Disorder	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
Neurologic	**Start Date**	**Stop Date or Ongoing**
☐ Insomnia	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Migraine Headaches	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Chronic Headaches	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Seizure Disorder	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Stroke / TIA	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Alzheimer’s Disease	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Dementia	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Diabetic Peripheral Neuropathy	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Post-Herpetic Neuralgia (PHN)	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
Skin	**Start Date**	**Stop Date or Ongoing**
☐ Psoriasis	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing
☐ Eczema	_____ / _____ / ________	_____ / _____ / ________ Or ☐ Ongoing

TANDEM Clinical Research
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Surgical History		
Surgery	**Date**	**Reason for Surgery**
	_____ / _____ / ________	
	_____ / _____ / ________	
	_____ / _____ / ________	
	_____ / _____ / ________	
	_____ / _____ / ________	
	_____ / _____ / ________	
	_____ / _____ / ________	
	_____ / _____ / ________	
	_____ / _____ / ________	
	_____ / _____ / ________	
	_____ / _____ / ________	
	_____ / _____ / ________	
	_____ / _____ / ________	

Do you anticipate or expect surgery in the next year? ☐ Yes ☐ No
If yes, please specify surgery/reason: ____

Any Other Medical Conditions		
Diagnosis	**Date**	**Stop Date or Ongoing**
	_____ / _____ / ________	
	_____ / _____ / ________	
	_____ / _____ / ________	
	_____ / _____ / ________	
	_____ / _____ / ________	
	_____ / _____ / ________	
	_____ / _____ / ________	
	_____ / _____ / ________	
	_____ / _____ / ________	
	_____ / _____ / ________	
	_____ / _____ / ________	
	_____ / _____ / ________	
	_____ / _____ / ________	

Prescription Medications				
Medication	**Current Dose**	**How Often**	**Start Date**	**Taken for What**
			_____ / _____ / ________	
			_____ / _____ / ________	
			_____ / _____ / ________	
			_____ / _____ / ________	
			_____ / _____ / ________	
			_____ / _____ / ________	
			_____ / _____ / ________	
			_____ / _____ / ________	
			_____ / _____ / ________	
			_____ / _____ / ________	
Over the Counter Medications				
Medication	**Current Dose**	**How Often**	**Start Date**	**Taken for What**
			_____ / _____ / ________	
			_____ / _____ / ________	
			_____ / _____ / ________	
			_____ / _____ / ________	
			_____ / _____ / ________	
			_____ / _____ / ________	
			_____ / _____ / ________	
			_____ / _____ / ________	
			_____ / _____ / ________	
			_____ / _____ / ________	

Patient Signature: ____ **Date:** _____ / _____ / ________

CRC/Investigator Signature: ____ **Date:** _____ / _____ / ________