ReTouched by ND
Dr. Naomi Dolly
Patient Intake Form

Today's Date:_____/____/_____

First Name:_____Middle Initial:_____Last Name: _____

Date of Birth:_____/____/_____ Gender: ☐ M ☐ F

Ethnicity: ☐ Caucasian ☐ African ☐ East Indian ☐ Hispanic ☐ Asian Other:_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Address:_____

Phone number: Mobile: _____ Home: _____

Email:_____

Occupation:_____

If retired or disabled enter your last occupation

Who is your primary care doctor: _____

Do you want us to send your primary care doctor a visit summary? ☐ Yes ☐ No

Where is your primary care doctor located ?_____

Phone number of primary care doctor:_____

Do you take any medications? ☐ Yes. ☐ No

If "yes" please list them and the dosage _____

Are you allergic to any medications? ☐ Yes ☐ No

If yes, list the medication(s) and reaction(s):

_____

_____

Do you smoke? ☐ Yes ☐ No How many years did you smoke? _____

If you quit, when did you stop?:_____ How many packs per day ? _____

Do you drink alcohol? ☐ Yes ☐ No If you quit, when did you stop?_____

Pertinent Family History _____

Do you have a history of skin cancer? ☐ Yes ☐ No

Does your family have a history of skin cancer? ☐ Yes ☐ No

Please continue to the next page

#27 Petra Street Woodbrook, Port of Spain
Email: caribbeandermdoc@gmail.com
Phone: 868-627-4891

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Do you have any children? ☐ Yes ☐ No If yes, how many? _____

Do your children have any medical problems: ☐ Yes ☐ No If yes, please specify _____

During your pregnancies were you diagnosed with high blood pressure/preeclampsia or diabetes? ☐ Yes ☐ No

Have you ever been treated for any of the following?

Have you ever been treated for any of the following?

Lupus	Yes No	Diabetes	Yes No	Stomach problems or Ulcers	Yes No
Breathing problems like Asthma or Emphysema	Yes No	High cholesterol	Yes No	Hepatitis	Yes No
Stroke	Yes No	Angina or chest discomfort	Yes No	Have you ever had any operations	Yes No
Heart murmur	Yes No	Heart attack	Yes No	Anemia or low blood count	Yes No
Anxiety	Yes No	Thyroid problems	Yes No	Kidney problems	Yes No
Rheumatoid disorder	Yes No				

Please list all other medical conditions:

_____

_____

Please list all prior hospitalization:

Date	Reason

Do you have any of these symptoms?

Weight loss	Yes No	Chest pain or pressure at exertion	Yes No	Headaches	Yes No
Palpitations or rapid beating heart	Yes No	Changes in bowel habits	Yes No	Seizures	Yes No
Shortness of breathe at rest	Yes No	Nausea/vomiting/ diarrhea	Yes No	Passing out episodes	Yes No
Unusual shortness of breathe on exertion	Yes No	Vomiting blood or blood in your bowel movements	Yes No	Temporary blindness	Yes No
Difficulty breathing at night	Yes No	Abdominal pain	Yes No	Numbness in arm or leg	Yes No
Chronic cough	Yes No	Excessive bleeding or Easy bruising	Yes No	Leg pain/fatigue with walking	Yes No
Chest pain or pressure at rest	Yes No	Painful urination	Yes No	Anxiety	Yes No

Briefly explain the reason for today's visit:

_____

How did you hear about Dr. Dolly's services? _____

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