

**Howard I. Glazer Ph.D.**  
**Behavioral Medicine/Pelvic Floor Neuromuscular Rehabilitation**  
**New York State License # 004694 Tax I.D. # 13-3195226**  
**500 West 43rd St #11A New York, N.Y. 10036**  
**2166 Broadway #6D New York, N.Y. 10024**  
**Phone/Fax: (212) 563-704**

**Medical Intake Form**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Age : \_\_\_\_\_

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

Gender: Female Male

Marital Status: Married Single Divorced Co-Habiting

#Children: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Person to Contact in Case of  
Emergency: \_\_\_\_\_

Relationship to  
Patient: \_\_\_\_\_

Phone: \_\_\_\_\_

How Did You Hear About Us?

- Yellow Pages
- Other Practitioner Who? \_\_\_\_\_
- Internet
- Current Patient Who? \_\_\_\_\_
- Our Website
- Other \_\_\_\_\_

If patient is a Minor, Name and Signature of Parent/Guardian(s)

Name \_\_\_\_\_ Signature \_\_\_\_\_

Patient Signature: \_\_\_\_\_

---

**HEALTH CONCERNS**

Please list your current health concerns in order from most bothersome to least bothersome. Please include Mental, Emotional, and Physical concerns

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_

**HOSPITALIZATIONS, SURGERIES, AND MAJOR ILLNESSES**

- |    | Date  | Condition or Procedure |
|----|-------|------------------------|
| 1) | _____ | _____                  |
| 2) | _____ | _____                  |
| 3) | _____ | _____                  |
| 4) | _____ | _____                  |
| 5) | _____ | _____                  |

## MEDICATIONS

Please list the medication and dosages that you are currently taking. Please include both prescription and over the counter.

Medication	Dosage
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____

## SUPPLEMENTS

Please list all of the supplements that you are currently taking including dosages and brand names.

Supplement	Dosage	Brand
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____

---

## ALLERGIES

Please list any medication, food, environmental or other allergy.

1)

---

2)

---

3)

---

---

## FAMILY HISTORY

	Children	Mother	Father	Sibling	Grandparent
Arthritis					
Thyroid					
Diabetes					
Tuberculosis					
Hypoglycemia					
Stroke					
Heart Attack					
Seizures					
Cancer					
Asthma					
Allergies					
Anemia					
Migraines					
Hepatitis					
Heart Disease					
Birth Defect					
High Blood Pressure					
Gall Bladder					
Alcoholism/Addiction					

---

**EYES****NOW PAST**

Nearsightedness or farsightedness

Blurred or failing vision

Dry, burning or itching eyes

Eyes water excessively

Night blindness

Bloodshot, red or puffy eyes

Mucus or discharge in eyes

Pain in eyes

**GENERAL****NOW PAST**

Tired, weak, lack of energy

Depression, moodiness

Worry, anxiety, nervousness

Sleeplessness or too much sleep

Frequent colds or other illnesses

Headaches

Dizziness, fainting, blacking out

Not enough/too much sweat  
or nightsweat**Ears****NOW PAST**

Earaches

Noises or ringing in ears

Ear discharges

Loss of hearing

Excess earwax

Difficulty hearing

**Chest****NOW PAST**

Cough frequently

Spitting up mucous or blood

Difficulty breathing

Chest pain

Wheezing

Palpitations

**Skin & Hair****NOW PAST**

Acne or pimples  
 Hives  
 Stretch marks  
 Skin ulcers or sores  
 Dryness, roughness or scaling skin  
 Hair loss or thinning  
 Dry, coarse hair  
 Bruise easily  
 Nails weak, ridged or split easily  
 Brown spots or bronzing on skin  
 Warts, moles or skin tags  
 Sunburn easily  
 Cuts heal slowly or scar badly  
 Flush easily  
 Athletes' foot.

**Nose & Throat****NOW PAST**

Allergies, sinusitis, runny nose  
 Dry mouth or nose  
 Nosebleeds  
 Cracks in corners of mouth  
 Dry or chapped lips  
 Sore throats or tonsillitis  
 Sore, red, or cracked tongue  
 Cold sores or herpes  
 Loss of smell or taste  
 Bleeding gums  
 Hoarseness  
 Grinding teeth  
 Dental problems  
 Difficulty swallowing

**Gastrointestinal****NOW PAST**

Loss of appetite  
 Nausea or vomiting  
 Bad breath  
 Metallic or bitter taste in mouth  
 Heartburn  
 Indigestion  
 Heaviness after eating  
 Bloating or gas  
 Belching  
 Constipation  
 Diarrhea

**Cardiovascular****NOW PAST**

Heart beats fast or irregularly  
 Tightness in chest  
 Discomfort in high altitude  
 Dizzy or weak on standing  
 Swollen feet, ankles or legs  
 Cold hands or feet  
 Hands or feet turn blue  
 Leg pain with walking  
 High blood pressure  
 Low blood pressure

**Bowel**

NOW PAST

Light colored or greasy stools

Undigested food in stool

Blood in stool or on paper

Hemorrhoids

Foul odor of stool or gas

Rectal pain/itching

**Bladder**

NOW PAST

Difficulty urinating

Urinate frequently at night

Bed Wetting

Incomplete urination or dribbling

Pain when urinating

Bladder or kidney infection

Kidney stones

Urine leakage

Blood in urine

**Female**

NOW PAST

Irregular periods

Pain prior to or with periods

Depressed irritable around periods

Painful or swollen breasts

Lumps in breast

Nipple discharge

Vaginal discharge

Vaginal pain or itching

Hot flashes

Diminished or excessive sex drive

Difficulty reaching orgasm

Inability to conceive

Miscarriages or abortions

Pelvic pain

Pain with intercourse

Heavy periods

Clitoral Pain

**Male**

NOW PAST

Prostate problems

Sexual difficulty

Genital discharge

Rashes or sores

Pain in genitals

Painful testicles

Painful ejaculation/orgasm

**Neurological**                      **Now**    **Past**

Tingling  
Numbness  
Involuntary Movement  
Loss of Sensation  
Neuropathies

**Musculoskeletal**                      **Now**    **Past**

Sacroiliac Joint  
Perineum Spasm  
Myofascial Trigger Points  
Low Back Pain  
Scoliosis

**Psychological**                      **Now**    **Past**

Anxiety  
Depression  
Anger Problems  
Substance Use  
Impulse Control Problems  
Social Withdrawal  
Hallucinations  
Paranoia

**Sexual**                                      **Now**    **Past**

Lack of Desire  
Lack of Arousal  
Unable to have orgasm  
Pain in Genitals  
Exhibitionism  
Sadism/Masochism  
Voyeurism  
Premature Ejaculation

**CONDITIONS**

**Please check any conditions you have had.**

- |                             |                             |                           |                           |
|-----------------------------|-----------------------------|---------------------------|---------------------------|
| <b>AIDS</b>                 | <b>Chemical Dependency</b>  | <b>High Cholesterol</b>   | <b>Prostate Problems</b>  |
| <b>Alcoholism</b>           | <b>Chicken Pox</b>          | <b>HIV Positive</b>       | <b>Psoriasis/Eczema</b>   |
| <b>Allergies</b>            | <b>Diabetes</b>             | <b>Kidney Disease</b>     | <b>Psychiatric Care</b>   |
| <b>Anorexia</b>             | <b>Emphysema</b>            | <b>Leg Cramps</b>         | <b>Rheumatic Fever</b>    |
| <b>Anemia</b>               | <b>Epilepsy</b>             | <b>Liver Disease</b>      | <b>Scarlet Fever</b>      |
| <b>Appendicitis</b>         | <b>Gall Bladder Disease</b> | <b>Measles</b>            | <b>Stroke</b>             |
| <b>Rheumatoid Arthritis</b> | <b>Glaucoma</b>             | <b>Migraine Headaches</b> | <b>Suicide Attempt</b>    |
| <b>Asthma</b>               | <b>Goiter</b>               | <b>Miscarriage</b>        | <b>Thyroid</b>            |
| <b>Bleeding Disorder</b>    | <b>Gonorrhea</b>            | <b>Mononucleosis</b>      | <b>Tonsillitis</b>        |
| <b>Breast Lump</b>          | <b>Gout</b>                 | <b>Multiple Sclerosis</b> | <b>Tuberculosis</b>       |
| <b>Bronchitis</b>           | <b>Heart Disease</b>        | <b>Mumps</b>              | <b>Typhoid Fever</b>      |
| <b>Bulimia</b>              | <b>Hepatitis</b>            | <b>Pacemaker</b>          | <b>Ulcers</b>             |
| <b>Cancer</b>               | <b>Hernia</b>               | <b>Pneumonia</b>          | <b>Vaginal Infections</b> |
| <b>Cataracts</b>            | <b>Herpes</b>               | <b>Polio</b>              | <b>STD's</b>              |
| <b>Lupus Erythematosis</b>  | <b>Sjogren's</b>            | <b>Graves Disease</b>     | <b>Addison's Disease</b>  |

**I certify that the above information is correct to the best of my knowledge.**

**Signature:**

**Date:**

**Print Name:**