

Sheryl M. Hakala, M.D., P.A.

3205 Southgate Circle, #10
Sarasota, FL 34239
(941) 375-2812



PATIENT INTAKE: MEDICAL HISTORY (To be completed by patient) Use the opposite side of the page as necessary to complete your answers. Please print legibly. Name _____

Address _____

Phone (w) _____ (h) _____ (c) _____

DOB _____ Age _____ SS# _____

Emergency Contact _____

Relationship to patient _____ Phone _____

Primary care physician _____ Phone _____

Date of last physical _____ Have you ever had an EKG? () N Date _____

Current or past medical conditions (check all that apply) () Asthma/respiratory () Cardiovascular (heart attack, high cholesterol, angina)

() Hypertension () Epilepsy or seizure disorder () GI disease

() Head trauma () HIV/AIDS () Diabetes

() Liver problems () Pancreatic problems () Thyroid disease

() STDs () Abnormal Pap smear () Nutritional deficiency

Other (Please describe) _____

If there a family history of any of the illnesses listed above, please put an "F" next to that illness

MD NOTES _____

Sheryl M. Hakala, M.D., P.A.

3205 Southgate Circle, #10
Sarasota, FL 34239



Is there a family history of anything NOT listed here? (Please explain) _____

MD NOTES _____

Have you ever had surgery or been hospitalized? (Please describe) _____

MD NOTES _____

Childhood Illnesses Measles () N () Y Mumps () N () Y Chicken Pox () N () Y

Have you or a family member ever been diagnosed with a psychiatric or mental illness? (Please describe)

Have you ever taken or been prescribed antidepressants? () N For what reason _____

Medication(s) and dates of use _____ Why stopped _____

Please list all current prescription medications and how often you take them (example: Dilantin 3x/day).

DO NOT include medications you may be currently misusing (that information is needed later) _____

Please list all current herbal medicines, vitamin supplements, etc. and how often you take them

MD NOTES _____

Please list any allergies you have (penicillin, bees, peanuts)

MD NOTES _____ Tobacco History

Cigarettes: Now? N Y In the past? N Y

Sheryl M. Hakala, M.D., P.A.

3205 Southgate Circle, #10



Sarasota, FL 34239

(941) 375-2812

How many per day on average? _____ For how many years? _____

Pipe: Now? () N () Y In the past? () N () Y How often per day on average? _____ For how many years?

Have you ever been treated for substance misuse? () N (Please describe when, where and for how long)

____ How long have you been using substances?

Substance Use History

	No	Yes/Past or Yes/Now	Route	How Much	How Often	Date/Time of Last Use	Quantity Last Used
Alcohol							
Caffeine (pills or beverages)							
Cocaine							
Crystal Meth-Amphetamine							
Heroin							
Inhalants							
LSD or Hallucinogens							
Marijuana							
Methadone							
Pain Killers							
PCP							
Stimulants (pills)							
Tranquilizers/ Sleeping Pills							
Ecstasy							
Other							

Sheryl M. Hakala, M.D., P.A.

3205 Southgate Circle, #10



Sarasota, FL 34239

(941) 375-2812

Did you ever stop using any of the above because of dependence? () N (Please list) _____

What was your longest period of abstinence? _____

MD NOTES _____