Medical Intake Form

Please fill out this form accurately to help us provide the best care.

Patient Information

Full Name: John Doe

Date of Birth (DD/MM/YYYY): 15/06/1985

Gender: ☑ Male ☐ Female ☐ Other

Address: 123 Main Street, Springfield

City: Springfield State: IL Zip Code: 62704

Phone Number: (217) 555-1234

Email: johndoe@email.com

Emergency Contact Name: Jane Doe

Emergency Contact Phone: (217) 555-5678

Relationship to Patient: Spouse

Insurance Information (If applicable)

Insurance Provider: Blue Cross Blue Shield

Policy Number: BCBS12345678

Group Number: GRP98765

Primary Insured Name: John Doe

Relationship to Patient: ☑ Self ☐ Spouse ☐ Parent ☐ Other

Medical History

Do you have any of the following conditions? (Check all that apply)

☑ Diabetes

☑ High Blood Pressure

☐ Heart Disease

☐ Asthma

☐ Allergies (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Kidney Disease

☐ Thyroid Problems

☐ Seizures

☐ Cancer (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking any medications?

☑ Yes (List below) ☐ No

Metformin (for Diabetes)

Lisinopril (for High Blood Pressure)

Do you have any past surgeries or hospitalizations?

☑ Yes (List below) ☐ No

Appendectomy (2015)

Lifestyle & Habits

Do you smoke? ☐ Yes ☑ No

Do you consume alcohol? ☑ Yes ☐ No

Do you exercise regularly? ☑ Yes ☐ No

Do you follow any special diet? ☑ Yes ☐ No (Specify): Low-carb diet

Symptoms & Current Concerns

Reason for today's visit:

☐ General Checkup

☐ Injury

☑ Illness

☐ Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Symptoms (if any):

☑ Fever

☑ Cough

☑ Shortness of Breath

☐ Chest Pain

☐ Nausea

☐ Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consent & Signature

I confirm that the information provided is accurate to the best of my knowledge.

Patient Signature: John Doe

Date: 02/03/2025

Guardian Signature (if patient is a minor): N/A

Date: N/A