Bring to your first appointment!

Patient Intake Form | Dr. Name: _____ Appt. Date: _____

Please bring the following to your appointment:

- This completed form
- Your immunization records
- All medications that you are currently using

Full Name: _____ Date Completed: _____
Date of Birth (Month/Day/Year): _____
Phone Numbers: Home: (__ __ __) - __ __ __ - __ __ __ __ Cell: (__ __ __) - __ __ __ - __ __ __ __ Circle Preferred Contact Number: Home / Cell May we leave medical messages? (Circle One): YES / NO
Email Address:
Do you have extended health benefits?
Who was your previous family physician?
Reason(s) for leaving your previous family physician?
Any known allergies to medication?
Other allergies?
Over the age of 65? Are you up to date on your: To make your response clear, please circle applicable options. Zostavax Pneumovax Tetanus Prevnar

Book an appointment at www.palermodocs.com

Bring to your first appointment!

Preventative Healthcare	Date last done	More than 3 years ago?	Result? Normal / More Information	Never done this test
PAP				
FIT				
Colonoscopy				
Bone Mineral Density				
Mammogram				

Past Medical History: Do you have any of the following conditions?

Central Nervous System	Cardiovascular	Respiratory
Yes / No - Cerebral Aneurysm Yes / No - Stroke Yes / No - Brain Tremor Yes / No - Seizure Disorder Yes / No - Neuropathy Yes / No - MS/MD	Yes / No - Hypertension Yes / No - High Cholesterol Yes / No - Valve Disease Yes / No - Heart Attack Yes / No - Irregular Heartbeat Yes / No - Pacemaker	Yes / No - Asthma Yes / No - COPD Yes / No - Bronchitis Yes / No - Tumors
Gastrointestinal	Genitourinary	Psychiatric
Yes / No - Hiatal Hernia Yes / No - Ulcer Yes / No - Crohn's Disease Yes / No - Colon Polyps Yes / No - Ulcerative Colitis Yes / No - Barrett's Disease	Yes / No - Kidney Disease Yes / No - Overactive Bladder Yes / No - STD's Yes / No - Benign Prostate Hypertrophy Yes / No - Are you pregnant?	Yes / No - Depression Yes / No - Anxiety Yes / No - Bipolar Disorder Yes / No - Schizophrenia Yes / No - PTSD Yes / No - Dementia/Alzheimer's
Bone Muscle	Infectious/Cancer	Metabolic
Yes / No - Arthritis Yes / No - Fibromyalgia Yes / No - Osteoporosis Yes / No - Chronic Pain	Yes / No - Hepatitis Yes / No - AIDS Yes / No - Tuberculosis Yes / No - Cancer	Yes / No - Liver Disease Yes / No - Diabetes Yes / No - Hyperthyroid Yes / No - Bleeding Disorder Type Yes / No - Overweight
Any other significant medical conditions?	Surgical History: (please list type and date)	Fractures/Broken Bones: (please list type and date)

Book an appointment at www.palermodocs.com

Bring to your first appointment!

Family History: (please list family members and any significant illness/disease they may have)		
Social History		
Occupation:	Marital Status (circle one): Married / Single / Widowed / Divorced	Children: Yes / No If yes, how many? ____ Grandchildren: Yes / No If yes, how many? ____
Who lives at home with you?		
Smoking (circle one)		
Never	Current	Ex-Smoker
If you answered with "Current" or "Ex-Smoker", please answer the following questions:		
Packs per day?		
How many years?		
At what age did you start?		
(if ex-smoker) At what age did you stop?		
Alcohol	How many drinks per week?	Do you have a history of alcohol abuse?
Drugs (circle one)		
Never	Occasionally	Frequently
What kind?		
Intravenous Drug Use? (circle one)	Yes	No