

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 |

| 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) |
| 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 |