Advanced Family Wellness Inc. PS
1115 west Bay Dr. NW, Suite 202
Olympia, WA 98502
Phone: (360)570-8010 / Fax: (360)570-8009

PATIENT INTAKE FORM

Name: _____ DOB: _____ Date: _____

What symptoms do you want Dr. Kather to address today? **Please note that the doctor may NOT be able to address all of your concerns in one visit. If you are here for a lab follow-up but have other concerns you want addressed, you may need to reschedule your lab appointment.** (If you are here for your lab follow-up please list the symptoms that necessitated the doctors' reason for ordering these labs).

When did these symptoms start? _____ How long do they last? _____

Do yours symptoms: persist or come and go? (Please circle your answer) (Explain as needed)

Please complete the **review of systems sheet** regarding other symptoms that you are experiencing and date it with today's date. Please write the **pertinent past medical history** – what has happened in your past that is significant about your complaints / concerns today?

What has happened in your **family medical history** that is pertinent to the symptoms that you have today?

*Are there any medications you are taking that need to be reviewed for refills during your appointment today? Please list them. **AFW now requires a medical visit to review medications you are taking before authorizing refill requests when: 1) a patient is not being seen regularly, 2) a patient has been prescribed a controlled substance, or 3) when the provider deems it necessary to discuss the request prior to authorizing a refill.**

What new medications or supplements have you started, changed or stopped since your last visit at Advanced Family Wellness? (Please list the date you started /stopped each medication or supplement.)

Do you have a medication list or medical history list for the medical assistant to copy and add to your chart today?

Yes / No (Please circle your answer)

What medications, food or environmental exposures are you allergic to?

What parts of your body are affected by your concern today? Please be specific.

Did you bring lab results or a diagnostic report today that accompanies your chief complaint of symptoms listed above?

Yes / No (Please circle your answer). If so, please ask the medical assistant to copy these for Dr. Kather to add to your chart.

Flip Over →

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Do you have Advance Directive? Yes / No (Please circle your answer)

*An advanced directive is a written statement of person's wishes regarding medical treatment, made to ensure those wishes are carried out should the person be unable to communicate to a doctor.

Date of your last annual exam: _____ Pap: _____

Date of your last eye exam: _____

Have you had any recent vaccinations?

VACCINATION		DATE:
HEP A	Y / N	
HEP B	Y / N	
Pneumonia	Y / N	
Tetanus	Y / N	
FLU	Y / N	
Shingles	Y / N	
HPV	Y / N	

Thank you for taking the time to help Dr. Kather and your medical insurer better understand how you wish to focus your medical visit today.