PATIENT INTAKE FORM

PERSONAL INFORMATION

Patient Name: _____ Date of Birth: ___/_____ /_____ Age: ____

Gender: ____ Wt: _____ Ht: _____ Marital Status:_____ Do you identify yourself as L G B T I

Occupation _____

Home Address: _____ City: _____Postal Code: _____

Phone Numbers: Home: _____ Work: _____ Cell: _____

Emergency contact: Name: _____ Relationship: _____ Phone: _____

Specialists: _____

Other Health Care Provider(s):_____

MEDICAL INFORMATION

Allergies, if known and reaction(medical, environmental, foods):_____

Current List of Medication/s & dosage:

List of Vitamins and other over-the-counter medications:

Past serious conditions, illnesses, injuries and/or hospitalizations & dates:

Your general state of health: ____Excellent _____Good ____ Fair ____ Poor

Please list your health concerns, in order of importance to you:

1._____ 3 _____

2. _____ 4._____

Family Health History: Has a close relative (parent, grandparent, sibling) had any of the following

	Arthritis		Cancer		Kidney Problems
	Tuberculosis		Stroke		Mental Health Problems
	Diabetes		Heart Problems		Multiple sclerosis
	Epilepsy/Seizures		High Blood Pressure		Osteoporosis
	High Cholesterol		Lung Problems & Asthma		Thyroid Problems

GENRAL HEALTH INFORMATION

Immunizations up to Date: Y / N

History of adverse reactions to immunizations: Y / N

Do you use any of the following? List the type and frequency if applicable:

	Alcohol			Laxatives	
	Antacids			Tylenol/aspirin/Advil	
	Caffeine			Recreational drugs	
	Cigarettes				

Are you currently pregnant? Y / N

How many pregnancies have you had:_____

Children & Age:_____ How were they born_____
Age:_____ How were they born_____
Age:_____ How were they born_____

Date of last pap: _____

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.) Y / N

PREV CARE: Date of Last:
FOBT/FIT Test:
Mammogram:
PAP:
Immunization:

Is there anything that you feel may be important for us to know?