NEW PATIENT INTAKE FORM

Full Name _____ Date of Birth _____

ALLERGIES ☐ NO ALLERGIES

ALLERGY	REACTION

PREFERRED PHARMACY? _____
ADDRESS _____

MEDICATIONS

NAME OF MED	DOSE	TIMES PER DAY
Ex. Aspirin	325 mg	Once daily

If you need more room to list medications, please write them on the back of this form

HEALTH MAINTENANCE HISTORY

BONE DENSITY	Date:	Abnormal Results? Y N
COLONOSCOPY	Date:	Abnormal Results? Y N
EYE EXAM	Date:	Abnormal Results? Y N
DENTAL EXAM	Date:	Abnormal Results? Y N
MAMMOGRAM	Date:	Abnormal Results? Y N
PAP SMEAR	Date:	Abnormal Results? Y N
CHOLESTEROL	Date:	Abnormal Results? Y N
PHYSICAL	Date:	Abnormal Results? Y N

PAST SURGERIES

TYPE (specify left/right)	DATE (Month/Year)

PERSONAL HEALTH HISTORY (even if resolved)

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Acid reflux			
Alcoholism/Drug Abuse			
Anemia			
Arthritis (type?)			
Asthma			
Cancer (type in comments)			
Depression/Anxiety/Bipolar			*Which condition?*
Diabetes			
COPD			
Gout			
Heart disease			
High Blood pressure			
Hypothyroid/thyroid disease			
Kidney disease			
Migraine headaches			
Seizures			
Sickle Cell Disease			
Stroke			
Suicidal attempt/thoughts			
Other:			
Other:			

SOCIAL HISTORY

Occupation (or prior occupation): _____

☐ Retired ☐ Unemployed ☐ LOA ☐ Disabled

Marital Status: ☐ Single ☐ Partner ☐ Married ☐ Divorced ☐ Widowed ☐ Other:_____

Tobacco Use? Y / N If yes, how many packs per day?_____ And for how long? _____

If NO, did you quit? Y / N If yes, when did you quit? _____ How many years did you smoke? _____

Do you drink alcohol? Y / N If yes, how many per day or week? _____

Do you use Caffeine? Y / N If yes, how many drinks per day? _____

Recreational drug use? Y / N If yes, what kind? _____

Do you eat a special diet? Y / N If yes, what kind? _____

Do you exercise regularly? Y / N If yes, how often and please describe _____

_____

Sexually Active? Y / N With which? Women / Men Birth Control Method? _____

FAMILY HISTORY (M= maternal, P = Paternal…grandmother/father)

☐ **"I am Adopted"**

☑ Check all that apply	Mother	Father	Sibling	Child	MGM	MGF	PGM	PGF
Asthma								
Bleeding Disorders								
Cancer (please specify type)								
Depression/Anxiety								
Diabetes								
Drug/Alcohol addiction								
Heart Disease								
High Blood Pressure								
High Cholesterol								
Kidney Disease								
Leukemia								
Liver disease								
Lymphoma								
Osteoporosis								
Rheumatoid Arthritis								
Stroke								
Thyroid disease								

OB/GYN HISTORY

Age of First Menses? _____

Menopause? Y / N Age? _____

History of Abnormal Pap? Y / N Approximate Date? _____

Painful periods? Y/ N Pain Rating 1-10? _____ Regular Periods? Y / N

PMS Symptoms? Y/ N Describe? _____

Pain during intercourse? Y/ N Pain rating 1-10? _____

Content with sex life? Y/ N

Abortions (how many?) _____ Full term births (How many?) _____

Infertility Issues? Y / N

Miscarriages (how many?) _____ Preterm births (how many?) _____

Total number of pregnancies _____ Tubal pregnancies _____

IMMUNIZATION HISTORY

Disease	Yes or No ?	If yes, write month/year
Chicken Pox (vax or disease)		
COVID-19		
Gardasil series		
Hepatitis B Series		
Normal TB screening		
Recent Flu Vaccine		
Recent PCV13 Vaccine		
Recent PPSV23 Vaccine		
Tetanus		
Other? _____		

CONTACT INFORMATION

Home Phone? _____

Mobile Phone? (required) _____

primary email address? (required)

_____

Physical Address? (required) _____

_____

Emergency Contact (Name and phone #) _____

_____