Name:___________________ DOB:__________________

NEW PATIENT INTAKE QUESTIONNAIRE

FULL NAME: ______________________________ **DATE OF BIRTH:** ______________
(Please provide drivers license or ID card for us to copy and place in your chart)

CONTACT INFORMATION:

Home Phone: ______________________ Cell Phone: ______________________________

EMAIL: ____

Address: ____

____

EMERGENCY CONTACT (Name, Phone #, relation to patient):

____

Anyone we discuss private information with (full name required):

____

INSURANCE INFORMATION (please provide card for us to photocopy and place in your chart):

Company: _______________ Identification #: ________________ Group #: ____________

*please note we do not accept insurance for membership but it can be used for labs, radiology, or specialists if necessary.

PREFERRED PHARMACY: ____

Address: ________________________________ Phone Number: ______________________

Please note we have a small pharmacy in office with great prices but we understand it is not always convenient for you to come to the office, so there is no obligation to use our pharmacy.
Also, please note we do not accept insurance for purchases made in our pharmacy.

ALLERGIES: ___ *No known drug allergies*

Allergy	Reaction	When did this occur?

Name:____________________ DOB:___________________

CURRENT MEDICATIONS:

Medication	Dose	Times per day

SOCIAL HISTORY:

Occupation (or prior occupation):____

___Retired ___Unemployed ___Disabled

Marital Status: ___Single ___Partner ___Married ___Divorced ___Widowed ___Other

SEX:_____________ GENDER:_______________ ORIENTATION:_____________________

Sexually Active: Y / N With: Men / Women / Both Birth Control Method:_______________

Do you smoke? Y / N Packs per day:_______ # years:________

If NO, did you ever smoke cigarettes/cigars/pipe/chewing tobacco? Y / N

If YES, for how long:_______ When did you quit?__________

Do you drink alcohol? Y / N If YES, how many drinks per day?___________

Do you use caffeine? Y / N If YES, how many drinks per day?___________

Do you use any recreational/illegal drugs? Y / N If YES, what kind?________________________

Do you eat any special diet? Y / N If YES, what kind?___________________________________

Do you exercise regularly? Y / N If YES, please describe:_________________________________

Name:___________________ DOB:__________________

PAST MEDICAL HISTORY

Disease/Condition	Current	Past (year)	Comments
Acid Reflux (GERD/heartburn)			
Alcoholism/Drug Abuse			
Anemia			
Arthritis (type in comments)			
Asthma/COPD			
Cancer (type in comments)			
Depression/Anxiety			
Diabetes (type in comments)			
Gout			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Migraines/Headaches			
Seizures			
Sickle Cell Disease			
Stroke			
Suicidal attempt/thoughts			
Thyroid disease (type in comments)			
Other:			
Other:			
Other:			

PAST SURGICAL HISTORY

Type (specify left/right)	Date (month/year)

Name:____________________ DOB:___________________

HEALTH MAINTENANCE HISTORY

Bone Density	Date:	Abnormal results: Y / N
Colonoscopy/Endoscopy	Date:	Abnormal results: Y / N
Eye Exam	Date:	Abnormal results: Y / N
Dental Exam	Date:	Abnormal results: Y / N
Pap smear	Date:	Abnormal results: Y / N
Mammogram	Date:	Abnormal results: Y / N

OB/GYN HISTORY

Age Period Started: __________ Menopause? Y / N At what age? __________

History of Abnormal Pap? Y / N When? ____________

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

Describe symptoms? ____

Pain during intercourse? Y / N Pain Rating 1-10? _________

Infertility issues? Y / N Total number of pregnancies ____________

Abortions #: __________ Miscarriages #: ____________

IMMUNIZATION HISTORY

Disease	**Yes / No**	**If yes, write month/year**
Chicken Pox (vaccine or disease)		
COVID-19		
Gardasil series		
Hepatitis B series		
TB screening		
Flu Vaccine		
Tetanus		

Name:____________________ DOB:__________________

FAMILY MEDICAL HISTORY

Check all that apply.	Mother	Father	Sibling	Child	Grandparent Maternal or paternal?
Asthma/COPD					
Bleeding Disorders					
Cancer — what type? ______________________					
Depression/Anxiety					
Diabetes Type 1 or Type 2					
Drug/Alcohol addiction					
Heart Disease					
High Blood Pressure					
High Cholesterol					
Kidney Disease					
Leukemia					
Liver Disease					
Lymphoma					
Osteoporosis					
Rheumatoid Arthritis					
Stroke					
Thyroid Disease					
Other:					
Other:					
Other:					