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:					