

New Patient Intake Form

Patient Name: _____ **Date of Birth:** _____

Have you received medical care from any other physician in the last 5 years? Yes No If yes, please give name and location.

Provider Name: _____ **Provider city and state:** _____

ALLERGIES

Do you have any allergies or bad reactions to medicines, foods or latex? Yes No If yes, please list them below.

Medicine, Food, Lates or other substance: _____ Reaction caused: _____

MEDICATIONS

Please list ALL medications you currently take (including birth control pills, vitamins, supplements and herbs) even if you do not take them every day, and even if they are over the counter.

Name of medication, vitamin, herb or supplement: Dosage (ex: how many mg and tablets you take) How often do you take it:

Name of medication, vitamin, herb or supplement:	Dosage (ex: how many mg and tablets you take)	How often do you take it:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Local Pharmacy: _____ **Mail Order:** _____

MEDICAL HISTORY

Have you ever had any of the following? Please check the boxes of all that apply to you.

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Cancer, other: _____ | <input type="checkbox"/> History of physical abuse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> History of sexual abuse | <input type="checkbox"/> Thyroid trouble |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Irritable Bowel Syndrome | |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Kidney stones | |
| <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Gerd/Reflux | <input type="checkbox"/> Migraines | |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Bladder problems | <input type="checkbox"/> Heart failure | <input type="checkbox"/> Sexually Transmittes Disease | |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Breast cancer, when _____ | <input type="checkbox"/> Heart Attack, when: _____ | <input type="checkbox"/> Skin cancer, when: _____ | |

Other: _____

Patient Name: _____ **Date of Birth:** _____

SURGICAL HISTORY

What surgeries or procedures have you had? Please check the boxes of all that apply to you.

- | | | | | |
|--|--|--|--|-------------|
| <input type="checkbox"/> Amputation, where: _____ | Year: _____ | <input type="checkbox"/> Hernia repair | <input type="checkbox"/> Left <input type="checkbox"/> Right | Year: _____ |
| <input type="checkbox"/> Appendix removed | Year: _____ | <input type="checkbox"/> Knee surgery | <input type="checkbox"/> Left <input type="checkbox"/> Right | Year: _____ |
| <input type="checkbox"/> Artificial joints, where: _____ | Year: _____ | <input type="checkbox"/> Neck surgery | | Year: _____ |
| <input type="checkbox"/> Back Surgery | Year: _____ | <input type="checkbox"/> Ovaries removed | <input type="checkbox"/> Left <input type="checkbox"/> Right | Year: _____ |
| <input type="checkbox"/> Breast surgery | <input type="checkbox"/> Left <input type="checkbox"/> Right | Year: _____ | <input type="checkbox"/> Stress test of heart | Year: _____ |
| <input type="checkbox"/> Cataract extraction | <input type="checkbox"/> Left <input type="checkbox"/> Right | Year: _____ | <input type="checkbox"/> Tonsils removed | Year: _____ |
| <input type="checkbox"/> Catheterization of heart | Year: _____ | <input type="checkbox"/> Tubes tied | | Year: _____ |
| <input type="checkbox"/> Gall bladder removed | Year: _____ | <input type="checkbox"/> Uterus removed | | Year: _____ |
| <input type="checkbox"/> Heart surgery | Year: _____ | <input type="checkbox"/> Vasectomy | | Year: _____ |

Description of surgery or other surgeries you have had: _____

IMMUNIZATION HISTORY

Are your childhood vaccinations up to date? Yes No Unsure Have you had the following vaccines?

- | | | | | | |
|---|--|-------------|---|--|--------------------------|
| <input type="checkbox"/> Flu (this year) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date: _____ | <input type="checkbox"/> Pertussis (whooping cough) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date: _____ |
| <input type="checkbox"/> Pneumonia (Pevnar) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date: _____ | <input type="checkbox"/> Tetanus | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date: _____ |
| <input type="checkbox"/> Shingles | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date: _____ | <input type="checkbox"/> COVID | <input type="checkbox"/> Yes <input type="checkbox"/> No | Brand: _____ Date: _____ |
| <input type="checkbox"/> Others: _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date: _____ | | | |

FAMILY MEDICAL HISTORY

Please indicate if your mother (m), father (f), sister (sis), brother (b), daughter (d), son (s) has a history of the following.

- | | | | |
|---|------------|--|------------|
| <input type="checkbox"/> Alcohol abuse | Who? _____ | <input type="checkbox"/> High blood pressure | Who? _____ |
| <input type="checkbox"/> Anesthesia complications | Who? _____ | <input type="checkbox"/> High cholesterol | Who? _____ |
| <input type="checkbox"/> Anxiety | Who? _____ | <input type="checkbox"/> Kidney disease | Who? _____ |
| <input type="checkbox"/> Asthma | Who? _____ | <input type="checkbox"/> Lung problems | Who? _____ |
| <input type="checkbox"/> Blood clots | Who? _____ | <input type="checkbox"/> Melanoma | Who? _____ |
| <input type="checkbox"/> Breast cancer, how old: ____ | Who? _____ | <input type="checkbox"/> Migraines | Who? _____ |
| <input type="checkbox"/> Colon cancer, how old: ____ | Who? _____ | <input type="checkbox"/> Osteoporosis | Who? _____ |
| <input type="checkbox"/> Cancer, other: _____ | Who? _____ | <input type="checkbox"/> Other mental illness | Who? _____ |
| <input type="checkbox"/> Depression | Who? _____ | <input type="checkbox"/> Prostate cancer, how old: _ | Who? _____ |
| <input type="checkbox"/> Diabetes, how old: _____ | Who? _____ | <input type="checkbox"/> Seizures | Who? _____ |
| <input type="checkbox"/> Drug abuse | Who? _____ | <input type="checkbox"/> Stroke, how old: _____ | Who? _____ |
| <input type="checkbox"/> Eczema | Who? _____ | <input type="checkbox"/> Thyroid trouble | Who? _____ |
| <input type="checkbox"/> Heart attack, how old: _____ | Who? _____ | <input type="checkbox"/> Other: _____ | Who? _____ |

If your father is deceased, how old was he when he died? _____ What did he die from? _____

If your mother is deceased, how old was she when he died? _____ What did she die from? _____