Patient Intake Information

Apogee Health Promotions utilizes an Electronic Medical Record that is not associated with UT Health or any other provider group. Because of this all information must be entered as new patient intake. Please fill out **ALL** of the following information. Do **NOT** leave blanks. Thank you for your understanding.

Name & Date: _____ **Previous Provider /location**:_____	**Preferred Pharmacy**

PERSONAL & FAMILY HISTORY

Allergies: *(include medication, food, and environmental allergies along with the reaction and severity)*	**Medical Diagnoses:**
Current Medications including Supplements and Alternative Meds:	**What are your current Health Concerns**?

Marital Status: Married Widowed Divorced Separated Never Married Living w partner

Spiritual Assessment

- In a typical week how often do you get together with friends or relatives? _____
- In a typical year, how often do you attend church or religious services? _____
- Do you have any personal or religious beliefs that would impact your healthcare? **Y / N**
  If yes, please explain:_____
- How important is your faith or spiritual belief in your life? Not important at all Not very important Mildly important Very important No opinion
- Do you have a religious preference?_____

Domestic Security

- Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner? **Y / N**
- Within the last year, have you been afraid of your partner or ex-partner? **Y / N**
- Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner? **Y / N**
- Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner? **Y / N**

Health Habits & Personal Safety

Exercise: Sedentary (no exercise) Mild exercise (walk- still able to carry on a conversation, normal daily activities) Occasional vigorous exercise (work out less than 4x/week) Regular vigorous exercise (workout to near exhaustion or vigorous activity 4 or more times per week)

Gender Identity

Male Female Trans-male Trans-female
Genderqueer Additional gender category:_____

Sexual Orientation

Straight or Heterosexual Lesbian, gay or homosexual
Bisexual Something else-*please specify:*

Social History

- Highest level of education: _____
- Occupation: _____
- Place of employment: _____
- How many individuals live in your Household?_____
- Describe your difficulty paying for the basics like food, housing, medical care & heating? Very hard Hard Somewhat hard Not very hard NYB
- Do you fee stressed, tense, restless, nervous or anxious or unable to sleep at night because your mind is troubled all the time – these days? Not at all Only a little To some extent Rather much Very much

Tobacco use:

- What type?_____ How much? _____
- What age did you start? _____

Alcohol Use:

- How often do you have a drink containing alcohol?_____
- How many standard drink containing alcohol do you have on a typical day? _____
- How often do you have 6 or more drinks on 1 occasion? _____

Recreational drugs:

Do you currently use recreational drugs, including marijuana? **Y / N**
Have you use recreational drugs in the past? **Y / N**
If yes, what substances? _____

Dates of Health Screening:			**Surgeries / Hospitalizations with dates:**
Colonoscopy:	Prostate:	PAP:	_____
Mammogram:	Bone Density:	AAA:	_____
Lung CA:			_____
			_____
Vaccinations:			_____
COVID Vac: (which one)			_____
Flu Vac:	Pneumonia:		_____
Shingles Vac:	Tetnus:		

Family History:	Name	Health Issues	Age	Alive
Paternal GM				Y / N
Paternal GF				Y / N
Father				Y / N
Maternal GM				Y / N
Maternal GF				Y / N
Mother				Y / N
Siblings				Y / N
				Y / N
				Y / N
Children				Y / N
				Y / N

PSYCHOLOGICAL HEALTH

Have ANY family members been diagnosed or treated for mental or emotional problems? Y / N

If yes, who & when?

What was their diagnosis?

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly every day
Little interest or pleasure in doing things?				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching TV				
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead or of hurting yourself in some way?				
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Some What difficult	Very difficult	Extremely difficult