MICHIGAN COMPASSIONATE CARE

Patient Intake Form

(fill as much as you can)

Date: _____

PATIENT NAME:_____	Home Phone # :_____
Cell Phone#:_____	Work Phone #:_____

NICKNAME:_____	Date of Birth:_____
	Gender: Male/Female
	Married: ☐ Yes ☐ No
	Children: ☐ Yes ☐ No
E-MAIL: _____	

MEDICAL PROBLEMS (past or current) e.g.: heart attack, high cholesterol, stroke, arthritis, depression, anemia, asthma, pain, diabetes, etc.

_____

_____

_____

SURGERIES (include year) e.g.: appendix, tonsils, heart bypass, knee surgery, etc.

_____

_____

_____

CURRENT MEDICATIONS TAKEN (prescription and over the counter include dose):

Drug Name Dose Freguency (Fill as much as you can)

_____

_____

_____

_____

_____

_____

_____

Patient Name_____	Date of Birth_____

ALLERGIES TO MEDICATIONS: ☐ No ☐ Yes, please fill in blanks below:

Medication:_____	Reaction:_____
Medication:_____	Reaction:_____
Medication:_____	Reaction:_____

OTHER DOCTORS OR SPECIALISTS YOU SEE:

Specialty:_____	Name:_____
Specialty:_____	Name:_____
Specialty:_____	Name:_____
Specialty:_____	Name:_____

HEALTH MAINTENANCE: When was your last?

Mammogram (female) _____

Pap Smear (female) _____

Colonoscopy _____

COVID Vaccine _____

Flu Vaccine _____

Pneumonia Vaccine _____

Shingles Vaccine _____

Last blood work up _____

DO YOUR PARENTS OR SIBLINGS HAVE ANY MEDICAL PROBLEMS?

DO ANY OTHER MEDICAL PROBLEMS RUN IN YOUR FAMILY? e.g. cancer, heart attack, colon cancer, etc.

_____

_____

_____

DO YOU SMOKE? ☐ NO ☐ YES ☐ FORMERLY

Maximum packs per day_____	Number of Years_____	When Quit _____

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO

If yes, how many drinks per week?_____

DO YOU USE ANY OTHER DRUGS? ☐ YES ☐ NO

If yes, what?_____

HOW WOULD YOU LIKE TO BE CONTACTED WITH TEST RESULTS, LABS, ETC.?

Telephone #_____ May we leave a message on a machine? ☐ YES ☐ NO

May we leave a message with a spouse or relative? ☐ YES ☐ NO

Patient Signature_____	Date_____
OR	
Guardian Signature_____	Date_____