Cedar Street Medical

Primary Care & Wellness

Est. 2023

PATIENT INTAKE AND HISTORY FORM

Name: _____ **Date of Birth:** _____ **Chart #** _____

Preferred Pharmacy: _____

(Address/City)

*****Should your information change, please report these changes in your address, phone contact numbers, insurance, or emergency contact, information to the front desk upon check in at future visits*****

Reason(s) for coming to the doctor today:

_____

• Do you currently **follow up with any other Provider/Specialist?** (Example: Cardiology, Neurology, Urology, Endocrinology, Infection disease, Mental Health, Nephrology, Therapy, Optometry, Orthopedics, ENT.) If so please list the provider(s) you are following up with:

_____

_____

Allergy History:

List known allergies (including medication allergies) and reaction to allergen. Or check one of the boxes below:

☐ No Known Allergies (NKA) ☐ No Known Drug Allergies (NKDA)

_____

_____

Medication History:

List any medications and vitamins/minerals/herbs that you are currently taking.

Ensure to **include Name, Dose, and Frequency of medication(s).** or Bring Medication Bottles or Completed List with you to appointments.

☐ No Current Meds

_____

_____

_____

_____

_____

_____

_____

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

Problem List/Past Medical History:

Have you been diagnosed with any of the following (currently or in the past)?

___ Abdominal Pain ___ GERD ___ Prostate Disease ___ Abnormal Vaginal Bleeding
___ Gout ___ Rash
___ Anemia ___ Headaches, Chronic ___ Rheumatic Fever ___ Anxiety ___ Heart Disease ___ Rubella
___ Arthritis ___ Heart Murmur ___ Scarlet Fever
___ Asthma ___ Heart Palpitations ___Seasonal Allergies ___ Back Pain ___ Hemorrhoids ___ Seizure
___ Cancer ___ Hepatitis ___ Sinusitis
___ Colitis, Ulcerative ___ High Blood Pressure ___ Sleep Disorder ___ COPD ___ Incontinence ___ Somnolence
___ Crohn's ___ Irritable Bowel ___ Stroke
___ Deep Vein Thrombophlebitis ___ Kidney Stone(s) ___ Tendinitis
___ Dementia ___ Measles ___ Thyroid Disorder ___ Depression ___ Migraines ___ Tuberculosis
___ Diabetes ___ MRSA Infection ___ Ulcer
___ Diverticulitis ___ Mumps ___ Urinary Frequency ___ Dizziness ___ Osteoporosis
___ Urinary Pain
___ ED (erectile dysfunction) ___ Polio ___ Vascular Disease, Peripheral ___ GI Bleed ___Guillain Barre Syndrome

List any other important **medical condition**(s) and **or Surgeries** you have had (do not include common colds or flu). Include date or age of initial diagnosis/surgery if possible: (continue on back if necessary)

_____

Surgical History:

_____ Appendix _____ Heart stent _____ PE/ Ear tubes _____ Gallbladder _____ C-Section
_____ Hernia _____ Tonsils _____ Splenectomy _____ Gastric Bypass _____ Mastectomy
_____ Pacemaker _____ Hysterectomy _____ Ovaries _____ Prostate _____ Heart bypass
_____ Joint replacement

Have you had any recent hospitalizations? If so, please list with related dates: _____

_____

Social History:

Do you use tobacco products? ☐Never used ☐Former use ☐Current use ☐Unknown How often? ☐Rare ☐Social ☐Daily
What type? ☐Cigarettes ☐Chewing Tobacco ☐Cigars

Have you ever used any illicit drugs? ☐Yes ☐No
How often? ☐Quit ☐Social Use ☐Regular Use ☐Daily Use **What type**? ☐Uses marijuana ☐Uses cocaine ☐Uses methamphetamines

Do you drink beverages with alcohol? ☐Yes ☐No
How often? ☐Occasional use ☐Moderate use ☐Heavy use What type? ☐Beer ☐Hard Liquor ☐Wine

What is your most recent primary occupation? _____

Family History:

Has any member of your family been diagnosed with any of the following conditions (include deceased family members)?

Father Mother Sister Brother Son Daughter, Maternal Grandmother(father), Paternal Grandmother(father)

Heart Disease _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
High Blood Pressure _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
Stroke _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
Cancer _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
Diabetes _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
Epilepsy/seizures _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
Bleeding Disorder _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
Kidney Disease _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
Thyroid Disease _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
Mental Illness _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

List any other important family medical condition(s) you are aware of (do not include common colds or flu). Include date of initial diagnosis if possible:

_____

_____

_____