TEXOMA PRIMARY CARE

NEW PATINET INTAKE FORM

Indicate preference: Kristina Halberg Brent Wetendorf No preference

Name:	**Sex:**
Date of Birth:	**Social Security #:**
Phone:	**E-mail:**
Address:	
***LIST ALLERGIES TO MEDS/MEDICAL PRODUCTS:**	

MEDICAL HISTORY: Check (√) all that apply		
High Blood Pressure	Stroke/CVA/TIA	LIST ALL SURGERIES & PROCEDURES:
Heart Disease	Seizures	
Heart Attack	Headaches	
High Cholesterol	Hepatitis	
Blood clots	Stomach ulcers	
Congestive heart failure (CHF)	Liver disease	
Diabetes	Arthritis	
Kidney Stones	Depression	
Cancer	Thyroid disease	
Asthma	OTHER:	
COPD		

SOCIAL HISTORY			**Occupation:**		
Marital Status: Please circle one	Single	Married		Divorced	Widowed
Caffeine intake:	Y/N	Coffee/tea/soda/energy drinks		How many/day:	
Alcohol intake:	Y/N	Social	Occasional	Rare	Daily / Weekly
Smoking Status: Please **circle** one	Never smoker	Current smoker Packs/Day_______		Ex-smoker Packs/Day_______ MM/YY Quit: _______	Vape/ Chewing tobacco/ Cigars

FAMILY HISTORY			
Father	Age	Alive? Y/N	Medical Problems:
Mother	Age	Alive? Y/N	Medical Problems:
Siblings	Age/s	Alive? Y/N	Medical Problems:
Sister/s			
Brother/s			
Grandparents	Age/s	Alive? Y/N	Medical Problems:
Maternal			
Paternal			

Previous PCP:
Names of specialists:
Name of Insurance:
Any family members seen at the clinic? Y/N :
How did you find out about us?
NAME OF PHARMACY:
REASON FOR APPOINTMENT:

<u>*REQUIRED: PLEASE PROVIDE LIST OF YOUR MEDICATIONS AND INCLUDE DOSE AND FREQUENCY***</u>**
<u>(NOT LISTING YOUR MEDICATIONS MAY DELAY YOUR VISIT/NEW PATIENT APPROVAL)</u>