Brief Medical Intake Form

1. Please enter your information.

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Gender:
○ Female ○ Male

Marital Status:
○ Single ○ Married ○ Domestic Partner
○ Separated ○ Divorced ○ Widowed

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone
○ Email

2. Emergency Contact Information.

Emergency Contact Name: _____ Relationship: _____ Phone: _____

3. Medical Insurance:

Primary Insurance Company _____ Member ID / Policy # _____ Group Number _____

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name _____ Insured Phone # _____ Insured Date of Birth _____ Insured Gender
○ Female ○ Male

Insured Street Address _____ Insured City _____ Insured State _____ Zip Code _____

4. Reason for today's visit:

_____

_____

_____

_____

5. Do you have any of these symptoms today:

- ☐ Fevers/Chills
- ☐ Dizzy/Lightheaded
- ☐ Loss of vision
- ☐ Hoarseness
- ☐ Persistent Coughing
- ☐ Ankle swelling
- ☐ Wake short of breath
- ☐ Bloating
- ☐ Heartburn
- ☐ Heavy/Painful menses
- ☐ Bleeding easily
- ☐ Skin rash
- ☐ Unexplained weight loss
- ☐ Headache
- ☐ Ear ringing
- ☐ Nose bleeds
- ☐ Shortness of breath
- ☐ Heart Palpitation
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Nausea/Vomiting
- ☐ Swollen glands
- ☐ Joint Pain/ Swelling
- ☐ Depression
- ☐ Night Sweats
- ☐ Blurry/double vision
- ☐ Facial pain/numbness
- ☐ Blood in Sputum
- ☐ Angina/Chest Pain
- ☐ Leg pain with walking
- ☐ Blood in stool
- ☐ Diarrhea
- ☐ Blood in urine
- ☐ Blood Clots
- ☐ Breast lump
- ☐ Poor sleep

Medical History

6. Do you have now or have you ever had:

	Yes	No		Yes	No
Anxiety	Yes	No	Asthma/COPD	Yes	No
Arthritis	Yes	No	Blood Clots	Yes	No
Bowel disease	Yes	No	Depression	Yes	No
Diabetes Type I	Yes	No	Heart Attack/Stroke	Yes	No
High Cholesterol	Yes	No	High Blood Pressure	Yes	No
Kidney Disease	Yes	No	Kidney Stones	Yes	No
Liver Disease	Yes	No	Neurologic Disorder	Yes	No
Osteoporosis	Yes	No	Seizures/Epilepsy	Yes	No
Thyroid Problems	Yes	No			

7. Do you have now or have you ever had:

	Yes	No	Location/Type
Cancer	Yes	No	
Radiation	Yes	No	
Other:	Yes	No	

8. Surgical History:

	Surgery	Month/Year
1		
2		
3		

9. Medication:

	Medication Name	Dosage	Frequency	Reason for taking
1				
2				
3				

10. Allergies:

	Allergy	Reaction
1		
2		
3		

Health

11. Do you:

	Yes	No	How many per day (packs/drinks)	Years
Smoke?	Yes	No		
Drink alcohol?	Yes	No		

12. Use recreational drugs?

○ Yes ○ No

If yes, please list kind:

_____

13. FEMALES:

Age at first period: _____

Date of last period: _____

Birth control:
○ Yes ○ No

Pregnancies: _____

#Births: _____

Pap smear: _____

Mammogram: _____

Family History

14. Do you have a family (parent, sibling or child) history of:

	Yes	No	If yes, who?
Heart Disease/Stroke	Yes	No	
High Blood Pressure	Yes	No	
Diabetes	Yes	No	
Cancer (Specify Type):	Yes	No	
Other	Yes	No	

If other, please specify:

_____

15. Would you like a flu vaccine?

○ Yes ○ No

16. Date of last Tetanus shot:

_____

17. Have you recently travelled outside of the country?

○ Yes ○ No

If yes, where?

_____

18. Do you exercise?

○ Yes ○ No

If yes, how much:

_____

19. Are you sexually active?

○ Yes ○ No