**New Patient Intake Form - Adult (>15 yrs)**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Social History:***

Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Religion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tobacco Use: Never Former Current Caffeine: (Type/Amount) \_\_\_\_\_\_\_\_\_ /Day # Hrs Sleep/night: \_\_\_\_\_\_\_

Alcohol/Recreational Drug Use: (Type/Amount/Frequency)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special Diet:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exercise Type/Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have Living Will/Advanced Directive: Yes No Concerns regarding abuse: Yes No

***Medical History:***

**Have you ever been Diagnosed with:**

Anemia Arthritis Asthma COPD Diabetes Bleeding Disorder

GERD Hepatitis Migraines Seizures Stroke High Blood Pressure

Anxiety Depression PTSD Bipolar ADHD Seasonal Allergies

Disease/Disorder of: Heart Kidney Liver Thyroid Gastrointestinal Tract Skin Immune System

Alcohol/Drug Addiction Other:

**Surgeries/Hospitalization/s:** (List What & Year)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Females:** Pregnant?  Yes  No Age of First Period?\_\_\_\_\_\_\_ Regular periods?  Yes  No

Date of Last Menstrual Period: \_\_\_\_\_\_\_\_\_\_ Current Form of Birth Control: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Medical History:** (Please list any Family Member with any of the following Conditions)

Cancer: Stroke: Mental Illness:

High Blood Pressure: Heart Disease: Diabetes:

Asthma: Other:

**Preventative Care/Immunizations:** List Most Recent: Physical Exam:\_\_\_\_\_\_\_\_\_ Bloodwork: \_\_\_\_\_\_\_\_\_\_

Dental Exam: \_\_\_\_\_\_\_\_ Eye Exam:\_\_\_\_\_\_\_\_ Colonoscopy:\_\_\_\_\_\_\_\_ Dexa Scan:\_\_\_\_\_\_\_\_

Mammogram:\_\_\_\_\_\_\_\_ WWE/Pap Smear:\_\_\_\_\_\_\_\_ Flu Shot:\_\_\_\_\_\_\_\_ Pneumonia Shot:\_\_\_\_\_\_\_\_

Tetanus Shot:\_\_\_\_\_\_\_\_ Zoster (Shingles):\_\_\_\_\_\_\_\_ Hepatitis A/B:\_\_\_\_\_\_\_\_ HPV:\_\_\_\_\_\_\_\_

**Current Medications:** Include Prescription and Non-Prescription, Inhalers, Vitamins, Etc.

Medication: Strength/Times Per Day: For What: Prescribed By:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergies to Medications:**  None  Yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Symptoms/Concerns you have Today: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Specialists Involved in your Care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Review of Systems: Please Circle Any Symptoms You are CURRENTLY Experiencing**

**General:**

Fatigue

Unexplained Weight Loss

**Allergic/Immunologic:**

Seasonal Allergies

**Endocrine:**

Intolerance to cold/heat

Excess Hair Growth / Loss

Excess thirst / urination

Nighttime urination

**Eyes/Ears/Nose/Throat:**

Hearing Loss

Dental Issues

**Heart/Circulatory:**

Chest Pain

Palpitations

Swelling of legs/feet

**Gastrointestinal:**

Difficulty Swallowing

Heartburn

Nausea/Vomiting

Diarrhea /Constipation

Black stool

**Genitourinary:**

Painful Urination

Dark colored urine

Blood in urine

Increased Frequency

**Heme/Lymphatic:**

Bleeding Tendencies

Easy Bruising

**Musculoskeletal:**

Joint Pain

Back / Neck Pain

Muscle Weakness

**Neurological:**

Blurred Vision

Headache

Dizziness

Numbness

**Respiratory:**

Chronic Cough

Hoarseness

Shortness of Breath

Wheezing

**Psychiatric:**

Anxiety

Depression

Suicidal Thoughts

**Skin:**

Rash

Itching

Changing Moles

**Pain:**

Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When did it start: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How have you treated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When did it start: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How have you treated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_