SAINT MOSCATI COMMUNITY HEALTH CARE

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.

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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: _____