Name:

DOB:

What are your priorities for your visit today?

Preferred Pharmacy: _____

Do you have an Advanced Directive: Yes No

How often have you been bothered by the below symptoms over the last two weeks?

Little interest or pleasure in doing things in the last 2 weeks? *Please circle*

Not at all Several days More than half the days Nearly every day

Feeling down, depressed, or hopeless in the last 2 weeks? *Please circle*

Not at all Several days More than half the days Nearly every day

Do you have any NEW allergies? IF SO, what type of reaction? *(If new patient, please disregard)*

Do you have any NEW medications *(if new patient, please disregard)*

Did you receive the flu vaccine in the prior flu season? Yes No

Did you receive the flu vaccine this current flu season? Yes No

Please answer if you are 65 years or older - Have you ever received a Pneumonia vaccine? Yes No

If yes, was it less than 5 years ago? Yes No

Social History

(For pediatric patients, please mark yes or no if there has been exposure in the household to the below items)

Category	**Yes**	**No**	**Usage**
Tobacco			
Vaping			
Alcohol			
Substance			

Fall Risk Assessment ***(Only answer if you are 65 years or older)***

Are you 65 years or older?	Yes	No
Have you had any falls within the past year?	Yes	No
Have you had a fall with injury?	Yes	No
Do you have a fear of falling?	Yes	No
Do you feel unsteady when standing or walking?	Yes	No

PATIENT INTAKE FORM

PATIENT INFORMATION

Today's Date:_____/ / Name: _____
Last Name First Name Middle Initial

DOB:_____/_____/_____ Age:_____ Gender: ☐ M ☐ F Height:_____Weight: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address: _____ _____ _____ _____
Street City State Zip Code

Home: (_____)_____Cell: (_____) _____

Work: (_____)_____Preferred Contact Number: Home ☐ Work ☐ Cell ☐

Email: _____

Emergency Contact:_____Emergency Phone: (_____) _____

Relationship to Patient: _____

Insurance Carrier: _____

Member ID: _____

Group Number: _____

Valid Date: _____

Subscriber Name and DOB if someone other than yourself: _____

YOUR HEALTH

What are your main concerns for the visit today? Please list in priority from 1 to 4.

1. _____
2. _____
3. _____
4. _____

CURRENT MEDICATIONS AND SUPPLEMENTS (That you're taking)	

ALLERGIES	
Medications/Supplements/Food/Environment:	**Reaction: (rash, nausea, shortness of breath, anaphylactic shock)**

ALCOHOL CONSUMPTION	TOBACCO CONSUMPTION
How many drinks currently per week? *1 drink = 5 ounces wine, 12 oz beer, 1.5 ounces spirits* □ None □ 1-3 □ 4-6 □ 7-10 □ > 10	☐ Past Smoker ☐Present Smoker How many years? _____ Packs per day: _____
Recreational Drug Use: ☐ Current ☐ Former ☐ Never ☐ Unknown	

REPRODUCTIVE HISTORY

Age of 1st Menses:_____

Date of Last Period:_____/_____/_____

Date of Last Pap Smear:_____/_____/_____

Date of Last Mammogram:_____/_____/_____

Date of Last Colonoscopy:_____/_____/_____

Date of Last Bone Density Scan:_____/_____/_____

MEDICAL AND SURGICAL HISTORY

DIAGNOSIS	DATE OF ONSET OR RESOLUTION

SURGERIES	DATE

FAMILY HISTORY

Please list any conditions or illnesses (i.e., cancers, high blood pressure, diabetes, autoimmune diseases, heart disease, blood disease, asthma, depression, substance abuse, celiac disease, IBS).

Family Member	Diagnosis	Age at Onset	If Deceased, Age of Death
Mother			
Father			
Brother			
Sister			
Paternal Grandmother			
Paternal Grandfather			
Maternal Grandmother			
Maternal Grandfather			