

Intake Form

Name: _____ Date of Birth: _____ Age: ____ Gender: _____
 Marital status: Single _____ Married _____ Other _____
 Address: _____
 City: _____ State: _____ Zip Code: ____
 Telephone (Cell): _____ (Home): _____ (Work): _____
 Email address: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone: _____
 Address: _____

Appointment reminders: Text message _____ Voice message _____
 Notification for medical bill: Text message _____ Email _____

Preferred Pharmacy: _____

Main concerns/health problems. List as many as you can in order of importance.

Do you have or have you had any of the following?

Please mark in the box:

(C) for current

(P) for past

Leave blank if not applicable to you

Thyroid disease		Diabetes/Prediabetes		Other endocrinological diseases	
Asthma		COPD		Cough	
Difficulty breathing		Pneumonia		Headache	
High blood pressure		Chest pain		Palpitation or fluttering	
Heart murmur		High cholesterol		Blood clots	
Anemia		Skin lesion/rash/mole		Lump or lymph node enlargement	
Low back pain		Joint pain/swelling		Autoimmune disease	
Insomnia		Problem focusing		Fatigue	
Vision problems		Cataract or glaucoma		Weight changes	
Earaches		Impaired hearing		ringing/vertigo	

Sore throat		Nose or gum bleeds		Sinus problems	
Abdominal pain		Heartburn/GERD		Nausea or vomiting	
Blood in stool		Trouble swallowing		Change in bowel movement	
Painful urination		Frequency of urination		Blood in urine	
Cancer		STI		Kidney stones	
Dizziness		Stroke		Seizure disorder	
Depression/ADHD		Anxiety /PTSD		Suicide history	
Female health					
Ovarian cysts		Breast lump		Last menstrual cycle	
Male health					
Hernia		Prostate disease		Testicular mass/pain	
Immunization					
COVID-19 vaccine		Flu vaccine		Zoster vaccine	
Pneumonia vaccine		Tdap vaccine		Hepatitis B vaccine	

FAMILY HISTORY

	Mother	Father	Siblings	Aunts/Uncles	MGM	MGF	PGM	PGF
Cancer								
Diabetes								
High blood pressure or heart disease								
Thyroid disease								
Asthma								
Mental illness								
Allergy/eczema								
Kidney disease								
Autoimmune disease								
Other/genetic disease								

Allergies: Drugs _____

Foods _____ Environmentals _____

Current prescription medications, over the counter medications, supplements.

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

Hospitalization and Surgery: _____ Major Trauma/Injury: _____

Signature:

Patient (18 years or older): _____ Date: _____

Parent, Guardian, Responsible Party: _____ Date: _____