

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: _____
 Is it ok to leave a message? _____
Is it ok to receive a text or voice message reminder for your appointment? _____
 Emergency Contact: _____ Relationship: _____ Phone: _____
 Address: _____

Preferred Pharmacy: _____

What are your main concerns/health problems? List as many as you can in order of importance.

- 1) _____
- 2) _____
- 3) _____
- 4) _____

Patient history

Please mark (x) the box that applies to you:

Thyroid disease	<input type="checkbox"/>	Goiter	<input type="checkbox"/>	Other endocrinological diseases	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	COPD	<input type="checkbox"/>	Cough	<input type="checkbox"/>
Difficulty breathing	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Headache	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	Palpitation or fluttering	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	Blood clots	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	Skin lesion/rash/mole	<input type="checkbox"/>	Lump or lymph node enlargement	<input type="checkbox"/>
Low back pain	<input type="checkbox"/>	Joint pain/swelling	<input type="checkbox"/>	Muscle pain	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	Problem focusing	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>
Vision problems	<input type="checkbox"/>	Cataract or glaucoma	<input type="checkbox"/>	Eye pain	<input type="checkbox"/>
Earaches	<input type="checkbox"/>	Impaired hearing	<input type="checkbox"/>	ringing/vertigo	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	Nose or gum bleeds	<input type="checkbox"/>	Sinus problems	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	Heartburn/GERD	<input type="checkbox"/>	Nausea or vomiting	<input type="checkbox"/>

Blood in stool		Trouble swallowing		Change in bowel movement	
Painful urination		Frequency of urination		Blood in urine	
Kidney stones		Stroke		Seizure	
Cancer		STI			
Depression		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	MGF
Cancer								
Diabetes								
High blood pressure or heart disease								
Thyroid disease								
Asthma								
Mental illness								
Allergy/eczema								
Kidney disease								
Autoimmune disease								
Other/genetic disease								

Allergies: Drugs _____
Any foods _____
Any environmental _____

Please list any prescription medications, over the counter medications, vitamins, or supplements you are currently taking:

- 1) _____ 2) _____ 3) _____
4) _____ 5) _____ 6) _____

Hospitalization and Surgery: _____ Major Trauma/Injury: _____

Patient (18 years or older) Date

Parent, Guardian, Responsible Party Date