

PATIENT INTAKE FORM

Date of appointment: _____

Account #: _____

Name: _____

Date of birth: _____

Address: _____

Phone (home): _____

Social security number: _____

Phone (cell): _____

Primary insurance: _____

Phone (work): _____

Policy number: _____

Email: _____

Secondary insurance: _____

Policy number: _____

Emergency contact: _____

Emergency contact phone: _____

REASON FOR ESTABLISHING CARE AND ANY PARTICULAR SYMPTOMS OR CONCERNS:

DRUG ALLERGIES (and reaction) and DRUG INTOLERANCES

PRESCRIPTION MEDICATIONS (name, dose, frequency)

NON-PRESCRIPTION MEDICATIONS (name, dose, frequency)

PAST MEDICAL AND SURGICAL HISTORY (any long term medical issues or prior procedures)

SOCIAL HISTORY

Marital status: _____ Children: _____

Occupation: _____

Tobacco Use (never, former, current - with amount, year of onset and/or year of quitting):

Alcohol Use: _____

FAMILY HISTORY (any illnesses that tend to run in your family)

HEALTH MAINTENANCE

Vaccinations: Influenza: __/__/__
Zostavax (shingles): __/__/__
Shingrx (shingles): __/__/__; __/__/__
Pevnar (pneumococcal): __/__/__
Pneumovax (pneumococcal): __/__/__
dT (tetanus): __/__/__
TDAP (tetanus/pertussis): __/__/__

Colonoscopy: __/__/__

PSA (prostate blood test): __/__/__ (men only)

Mammogram: __/__/__ (women only)

DEXA (bone density): __/__/__

Have you ever been screened for hepatitis C? _____

Any additional vaccinations and dates: _____