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:

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DRUG ALLERGIES (and reaction) and DRUG INTOLERANCES

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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)

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____

HEALTH MAINTENANCE

Vaccinations:

Influenza: —/—/___

Zostavax (shingles): —/—/___

Shingrx (shingles): —/—/—; —/—/___

Prevnar 13 or 20 (pneumococcal): —/—/

Pneumovax (pneumococcal): —/—/ ___dT

(tetanus): - —J—/___

TDAP (tetanus/pertussis): —J—/ ___

COVID __________________

colonoscopy: —/—/___

PSA (prostate blood test): —J/—J— (men only)

Mammogram: 3—J_ (women only)

DEXA (bone density): —/—/___

Have you ever been screened for hepatitis C?

Any additional vaccinations and dates:

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