NEW PATIENT INTAKE AND HISTORY FORM (*updated 11/16/19*)
(Please print)

Date: ____________________
Name: ____ **Date of Birth:** ____________________

Local Pharmacy: ____
(Name/City/Phone #)

Mail Order Pharmacy: ____
(Name/City/Phone #)

PROBLEM LIST/PAST MEDICAL HISTORY:

Have you been diagnosed with any of the following (currently or in the past)?

___ Abnormal Heart Rhythm
___ Alcoholism/Substance Abuse
___ Alzheimer's
___ Anemia
___ Angina (chest pain)
___ Anxiety
___ Arthritis
___ Asthma
___ Bipolar Disorder
___ Bleeding Disorder
___ Blood Clots
___ BPH – Prostate enlargement
___ Cancer
___ Cataract
___ Chronic Kidney Disease
___ Colon Polyps
___ Congenital Heart Disease
___ Congestive Heart Failure
___ COPD
___ Coronary Artery Disease
___ Crohn's Disease
___ CVA/Stroke
___ Depression
___ Diabetes – Type 1
___ Diabetes – Type 2
___ Diverticulitis
___ Emphysema
___ Fibromyalgia

___ Gallstones
___ Gastric Reflux
___ Genital Herpes Simplex
___ GERD, Reflux
___ Gallstones
___ Glaucoma
___ Gout
___ Heart Murmur
___ Headache/ Migraine
___ Hepatitis
___ High Blood Pressure
___ High Cholesterol
___ HIV/AIDS
___ IBS
___ Kidney Disease
___ Kidney Stones
___ Liver Disease/ Hepatitis
___ Lupus
___ Macular Degeneration
___ Menopause/Age
___ Memory Loss
___ Obesity
___ Osteoarthritis
___ Osteoporosis
___ Pancreatitis
___ Parkinson
___ Pneumonia
___ Rheumatoid Arthritis

___ Rheumatic Fever
___ Seasonal Allergies
___ Seizures
___ Shingles
___ Sleep Apnea
___ Stomach Ulcers
___ Thyroid
___ TIA (mini stroke)
___ Tuberculosis

Other____________________
____
____
____

Comments____________________
____
____
____
____
____
____

ALLERGY HISTORY: Please include all allergies such as medication and/or medical supplies (i.e: latex, iodine or tape

☐ **None** ☐ **NKDA (No Known Drug Allergies)**

_____Acetaminophen/reaction__________________

_____Epinephrine/ reaction__________________

_____ Latex/ reaction__________________

_____Lidocaine/reaction__________________

_____Sulfa Drugs/ reaction__________________

_____ Aspirin/reaction__________________

_____ Erythromycin/ reaction__________________

_____ Lidocaine/reaction__________________

_____ Penicillin/reaction__________________

Name of other medications

____

____

Reactions:

____

____

MEDICATION HISTORY:

☐ I am not currently taking any medications

List any medications, vitamins, minerals, and herbals that you are currently taking:

Name of Medication	Dosage	How Often

FAMILY HISTORY:

Has any member of your family been diagnosed with any of the following conditions (include deceased family members)? Place an "X" under the correct family member with the condition and indicate if the family member passed away due to that condition.

	Mother	Father	Sister	Brother	Mother's Parents	Father's Parents
Arthritis						
Asthma						
Cancer						
Cataract						
COPD						
Dementia						
Depression						
Diabetes						
Heart Disease						
High Blood Pressure						
High Cholesterol						
Kidney Disease						
Lung Disease						
Mental Illness						
Neurologic Conditions						

	Mother	Father	Sister	Brother	Mother's Parents	Father's Parents
Obesity	______	______	______	______	______	______
Osteoporosis	______	______	______	______	______	______
Seizures	______	______	______	______	______	______
Stroke	______	______	______	______	______	______
Thyroid Problems	______	______	______	______	______	______
Tuberculosis (TB)	______	______	______	______	______	______

PAST SURGICAL HISTORY:

☐ **None**

___ Angioplasty (stent)
___ Appendectomy
___ Back Surgery
___ Breast Surgery, Left
___ Breast Surgery, Right
___ Cataract Surgery, Left
___ Cataract Surgery, Right
___ Cholecystectomy
___ Coronary Art. Bypass
___ Hemorrhoidectomy
___ Hernia Repair
___ Hip Replacement, Left
___ Hip Replacement, Right
___ Knee Replacement, Left
___ Knee Replacement, Right
___ Neck Surgery
___ Shoulder Replacement, Left
___ Shoulder Replacement, Right
___ Sinus Surgery
___ Thyroidectomy, Left
___ Thyroidectomy, Right
___ Tonsillectomy

Other: ____

Females Only:

___ Cesarean Delivery
___ Total Hysterectomy (uterus and cervix removed)
___ Partial Hysterectomy (uterus only removed)
___ Number of Pregnancies
___ Ovary Removal, Left
___ Ovary Removal, Right
___ Tubal Ligation
___ Number of Deliveries

SOCIAL HISTORY:

Marital Status: ☐ Single ☐Married ☐Separated ☐Divorced ☐Widowed

Children ___Yes ___No **Sons**_____ **Daughters**______

Occupation:________________________________

Do you exercise: ____Yes ____No **If yes, how many times per week/time spent:** __________________

Type of exercise:________________________________

Please describe your current tobacco use:

☐Smoker, current status unknown ☐Light tobacco smoker ☐Heavy tobacco smoker ☐Current every day smoker ☐Current some day smoker ☐Former smoker ☐Never smoker ☐Unknown if ever smoked

If you currently use tobacco or have in the past, please indicate what type (cigarettes, cigars, pipe, chew) and how many years: ____

Do you drink alcoholic beverages? ☐Yes ☐No

If yes, please indicate how many drinks: ____________________ per day / week / month (circle one)

Do you use marijuana? ☐Yes ☐No If yes, please check: ☐ THC/CBD ☐ CBD only

Hemp products used: ____

Have you ever used any illicit drugs? ☐Yes ☐No

If yes, please indicate what type of drug and how often: ______________________________

Please describe your sexual preference: ☐Bisexual ☐Heterosexual ☐Homosexual ☐Unknown

Are you sexually active? ☐Yes ☐No **My partner is:** ☐Male ☐Female