

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

Date: _____ **Date of Birth:** _____

Name: _____

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)?

- | | | |
|---|---|---|
| <input type="checkbox"/> Abnormal Heart Rhythm | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Alcoholism/Substance Abuse | <input type="checkbox"/> Gastric Reflux | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Genital Herpes Simplex | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> GERD, Reflux | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Angina (chest pain) | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gout | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> TIA (mini stroke) |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Headache/ Migraine | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Hepatitis | Other _____ |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> High Blood Pressure | _____ |
| <input type="checkbox"/> BPH – Prostate enlargement | <input type="checkbox"/> High Cholesterol | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV/AIDS | _____ |
| <input type="checkbox"/> Cataract | <input type="checkbox"/> IBS | Comments _____ |
| <input type="checkbox"/> Chronic Kidney Disease | <input type="checkbox"/> Kidney Disease | _____ |
| <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Kidney Stones | _____ |
| <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Liver Disease/ Hepatitis | _____ |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Lupus | _____ |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Macular Degeneration | _____ |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Menopause/Age | _____ |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Memory Loss | |
| <input type="checkbox"/> CVA/Stroke | <input type="checkbox"/> Obesity | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Osteoarthritis | |
| <input type="checkbox"/> Diabetes – Type 1 | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Diabetes – Type 2 | <input type="checkbox"/> Pancreatitis | |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Parkinson | |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Pneumonia | |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Rheumatoid Arthritis | |

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 _____	_____ Aspirin/reaction _____
_____ Epinephrine/ reaction _____	_____ Erythromycin/ reaction _____
_____ Latex/ reaction _____	_____ Lidocaine/reaction _____
_____ Lidocaine/reaction _____	_____ Penicillin/reaction _____
_____ Sulfa Drugs/ 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:

<u>Name of Medication</u>	<u>Dosage</u>	<u>How Often</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Other: _____

Females Only:

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

REVIEW OF SYSTEMS:

Please place a check mark in the box next to any of the following symptoms or problems if you have experienced them recently or have concerns about them. If you don't understand something place a question mark "?" by it. Your doctor will discuss any positive responses with you.

General: Normal

- Appetite Loss
- Fatigue
- Fever
- Night Sweats
- Weight Change

Skin: Normal

- Acne
- Bruising
- Dryness
- Excessive Sweating
- Hair Loss
- Itching
- New Lesions
- Rash

HEENT: Normal

- Blurred Vision
- Eye Redness
- Headache
- Hearing Loss
- Seasonal Allergies

Neck: Normal

- Neck Mass
- Swollen Glands

Respiratory: Normal

- Cough
- Difficulty Breathing
- Wheezing

Breast: Normal

- Breast Mass
- Breast Pain
- Breast Swelling
- Skin Changes

Cardiovascular: Normal

- Chest Pain
- Elevated Blood Pressure
- Shortness of Breath
- Swelling of Extremities

Gastrointestinal: Normal

- Abdominal Pain
- Constipation
- Diarrhea
- Nausea
- Vomiting

Genitourinary: Normal

- Blood in Urine
- Frequency
- Incontinence
- Painful Urination

Musculoskeletal: Normal

- Back Pain
- Joint Pain
- Joint Swelling

Neurological: Normal

- Dizziness
- Fainting
- Numbness
- Seizures

Psychiatric: Normal

- Anxiety
- Depression
- Easily Irritated
- Memory Loss

Endocrine/Glands: Normal

- Appetite Changes
- Cold Intolerance
- Thyroid Problems

Hematology: Normal

- Anemia
- Blood Clots
- Easy Bruising
- Easy Bleeding