MEDICAL INTAKE FORM

Patient Name: _____ DOB: _____

Pharmacy: _____

Medications you currently take:

MEDICATION	DOSAGE	TIME(S) OF DAY YOU TAKE IT

(Please use back of form if you require more space)

Allergic Reactions to Medicine or Food:

Medication/Food Allergy	Reaction
_____	_____
_____	_____
_____	_____

Patient Medical History: (Circle All That Apply)

Heart Disease	Hypertension	Depression	HIV
Seizures	Stroke	Cholesterol	Ulcers
Asthma	Lung Disease	Cancer	Other:
Allergies	Arthritis	Thyroid Disease	_____
Acid Reflux	Back Trouble	Tuberculosis	_____
Obesity	Hypotension	Anxiety	_____
Bronchitis	Diabetes	Hyperlipidemia	_____
Migraines	Kidney Disease	Major Infection	_____
Glaucoma	Anemia	Hepatitis	_____

Surgical/Hospitalization History: (List procedure/cause and year/date)

_____ _____

_____ _____

Family History: (Circle status and check all that apply)

	Status	Age	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Mental Health
Father	Alive/Deceased							
Mother	Alive/Deceased							
Brother	Alive/Deceased							
Sister	Alive/Deceased							
Son	Alive/Deceased							
Daughter	Alive/Deceased							

Social History:

Tobacco Use:	Never	Previously But Quit	Yes	Packs/day:
Use of Alcohol:	Never	Previously But Quit	Yes	Amount:
"Recreational Drugs"	Never	Previously But Quit	Yes	Which?

Please list people you currently live with: _____

Are you: ____ Single ____ Married ____ Divorced ____ Other? (Specify: _____)

Have you ever been a victim of physical, emotional or sexual violence? Y / N

What is your occupation? Please include any unusual or potentially dangerous exposures you might have at work: _____

Health Maintenance:

Please list the year of your last screening test below: (please indicate if there were any abnormal results)

Colonoscopy: _____ Eye Exam: _____ Blood Work: _____

Dental Exam: _____ Prostate Exam: _____

Are your immunizations up to date? Y / N

Please list the types of exercise you participate in: _____

How often do you exercise per week? _____ How long do you exercise for at this time? _____

WOMEN ONLY:

Date of last period: _____ Are you currently on birth control? Y / N Date of last PAP: _____

Have you ever had an abnormal PAP? Y / N Date of last Mammogram: _____