PATIENT INTAKE FORM

Date of appointment: ____________ **Account #:** ____________

Name: ______________________________ Date of birth: ______________________________

Address: ______________________________ Phone (home): ______________________________

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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

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PRESCRIPTION MEDICATIONS (name, dose, frequency)

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NON-PRESCRIPTION MEDICATIONS (name, dose, frequency)

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

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SOCIAL HISTORY

Marital status: ____________________ Children: ______________________________

Occupation: ____

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

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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 (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: ____