Name _____ Date of Birth _____

Patient Intake Form

Please fill out this form to the best of your knowlede. Your answers help us plan and provide your care.

Advance Directive	Yes	No
Do you have a power of attorney?		
Do you have a living will? Do not resuscitate?		

Current Prescriptions *(list all medications you are taking at present)*

Medication name	Dosage/ Route	How often
Example: Lasix	*20 mg, PO*	*Daily*

Any medication allergies? _____

Mental Health

Over the last 2 weeks, how many days have you:	None	Several days	More than half the days	Most days
Had little interest or pleasure in doing things?				
Felt down, depressed or hopeless?				

Past Medical History (*check all that apply)*

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood clot *(DVT/PE)*
- ☐ Coronary artery disease (*Heart attack)*
- ☐ COPD/emphysema
- ☐ Cancer/History of cancer
- ☐ Chronic kidney disease
- ☐ Chronic liver disease/cirrhosis
- ☐ Congestive heart failure
- ☐ Depression
- ☐ Diabetes Type I/II
- ☐ GERD
- ☐ Hepatitis (type ____)
- ☐ Hypertension *(High blood pressure)*
- ☐ Hyperlipidemia (*High cholesterol)*
- ☐ Migraine
- ☐ Seizure
- ☐ Stroke
- ☐ Thyroid (hypo/hyper)

Please list any other conditions not mentioned above: _____

_____

Past Surgical History *(check all procedures that apply)*

- ☐ Appendectomy
- ☐ Coronary artery bypass (*open heart)*
- ☐ Cholecystectomy (*removal of gallbadder)*
- ☐ Gastric bypass
- ☐ Hysterectomy (*removal of uterus)*
- ☐ Joint repair/replacement (*i.e hip, knee, shoulder)*
- ☐ Nephrectomy (*removal of kidney)*
- ☐ Spinal surgery
- ☐ Splenectomy (*removal of spleen)*

Please list any other procedures not mentioned above: _____

_____

_____

Social History	Yes/ How much or often	No
Do you smoke tobacco?		
Do you drink alcohol?		
Have you ever struggled with addiction? If yes, have you been sober?		

Family History (*please indicate first degree relatives only)*

- ☐ Anemia
- ☐ Asthma
- ☐ Blood clot *(DVT/PE)*
- ☐ Coronary artery disease (*Heart attack)*
- ☐ COPD/emphysema
- ☐ Cancer
- ☐ Chronic kidney disease
- ☐ Chronic liver disease/cirrhosis
- ☐ Congestive heart failure
- ☐ Depression
- ☐ Dementia
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Hypertension *(High blood pressure)*
- ☐ Hyperlipidemia (*High cholesterol)*
- ☐ Osteoporosis
- ☐ Seizure
- ☐ Skin condition
- ☐ Stroke
- ☐ Thyroid (hypo/hyper)

Preventive Care	Date	Result
Colonoscopy		
CT of the chest (*lung cancer screening)*		
Mammogram		
Pap smear		

Would you be interested in learning more about *(check all that apply)***:**

- ☐ Botox
- ☐ Foot and ankle care/ perpiheral neuropathy
- ☐ IV therapy (fluid hydration, vitamin injection)
- ☐ Skin care products

Anything else you would like to share with the provider? _____

_____

_____

How did you hear about us? _____