Medical Intake Form

PATIENT NAME: _____ DOB: _____ EMAIL: _____

REASON FOR VISIT: _____

PHARMACY NAME AND ADDRESS: _____

PLEASE *PROVIDE A COPY* OF YOUR MEDICATIONS INCLUDING DOSAGE AND FREQUENCY OR LIST HERE:

_____ _____

_____ _____

_____ _____

_____ _____

PLEASE USE BACK OF FORM IF MORE ROOM IS NEEDED

PLEASE LIST ANY ALLERGIES: _____

_____

PATIENT MEDICAL HISTORY: *(CIRCLE ALL THAT APPLY)*

HEART DISEASE	HYPERTENSION	HYPOTENSION	HYPERCHOLESTEROLEMIA	HYPERLIPIDEMIA
SEIZURES	STROKE	DIABETES	CANCER	MAJOR INFECTION
ASTHMA	LUNG DISEASE	KIDNEY DISEASE	THYROID DISEASE	HEPATITIS
MIGRAINE HEADACHES	ARTHRITIS	ANEMIA	TUBERCULOSIS	HIV
GLAUCOMA	BACK TROUBLE	DEPRESSION	ANXIETY	ULCERS

LIST ANY OTHER DISEASES: _____ _____ _____

FAMILY HISTORY: *(CIRCLE STATUS AND CHECK ALL THAT APPLY)*

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

SURGICAL HISTORY: *(LIST PROCEDURE AND DATE)*

_____ _____

_____ _____

SOCIAL HISTORY:

TOBACCO USE:	NEVER	PREVIOUSLY BUT QUIT	YES	PACKS/DAY _____
USE OF ALCOHOL:	NEVER	PREVIOUSLY BUT QUIT	YES	AMOUNT _____
USE OF "RECREATIONAL DRUGS":	NEVER	PREVIOUSLY BUT QUIT	YES	WHAT? _____

Work History: ___ Employed ___ Unemployed ____ Disabled ____ Retired