NEW PATIENT MEDICAL INTAKE QUESTIONNAIRE

NAME: _____ GENDER: _____ DOB: _____ DATE: _____

Preferred Pharmacy: _____ Preferred Pharmacy Address:_____

ALL MEDICATIONS: (Including over-the-counter medications and vitamins). Specific doses and when taken. If you don't know, please call your pharmacist to confirm.

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES: _____

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

ADHD/ADD	Diabetes: Type 1 or 2	Kidney Disease/Stones
Alcoholism/Substance Abuse	Diverticulosis/Diverticulitis	Liver Disease/Cirrhosis
Anemia	Eczema/Psoriasis/Rashes/Acne	Mental Illness: Anxiety/Depression/Bipolar
Arrhythmias/Irregular Heartbeat	Fibromyalgia	Neuropathy
Arthritis	Headaches/Migraines	Osteopenia/Osteoporosis
Asthma/COPD/Emphysema	Hearing Impairment	Pulmonary Embolism/Blood Clots
Autoimmune Disorders: AS/Lupus/Thyroid/RA	Heart Disease: Heart Attack/Chest Pain/Angina	Seasonal Allergies
Back Pain/Neck Pain	Heavy Menstrual Bleeding/Cramping	Seizure Disorder
Bladder Problems/Incontinence	Hepatitis: A B C / HIV	Sleep Apnea/Sleep Disorder
Cancer:_____	Hernia: _____	Stroke
Chron's/Celiac Disease/Ulcerative Colitis	High Blood Pressure/High Cholesterol	Vision Problems/Glaucoma
Dementia/Alzheimer's	IBS/GERD/Stomach Ulcer	Weight Gain/Weight Loss

Last Colonoscopy Date: _____ Normal _____ Abnormal _____

Other medical problems not listed above:

_____

Last Menstrual Period Date: _____ Normal _____ Abnormal _____

Hysterectomy Date: _____

Type: (circle all that apply) Partial (remove uterus) Total (remove uterus/cervix) Complete (remove uterus/cervix/ovaries)

Last Mammogram Date: _____ Normal _____ Abnormal _____

Last Dexa (Bone Density Scan): _____ Normal _____ Abnormal _____

Last Pap Smear: _____ Normal _____ Abnormal _____

Last Diabetic Retinal Screen _____ Normal _____ Abnormal _____

Last Colon Cancer Screen _____ Normal _____ Abnormal_____

Surgical History:

_____

SOCIAL/CULTURAL HISTORY

Education Level: ☐ Elementary ☐ High School ☐ Vocational ☐ College ☐ Graduate / Professional
Are there any vision/hearing problems that affect your communication? ☐ Yes ☐ No
Are there any limitations to understanding or following instructions (either written or verbal)? ☐ Yes ☐ No
Are there any problems or concerns at home, work or school you would like to discuss? ☐ Yes ☐ No
Are there any cultural or religious concerns you have related to our delivery of care? ☐ Yes ☐ No
Are there any financial issues that directly impact your ability to manage your health? ☐ Yes ☐ No
How often do you get social and emotional support? ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐Never

Current Living Situation (Check all that apply):
☐ Single Family ☐ Multi-generational ☐ Homeless ☐ Shelter ☐ Skilled Nursing Facility ☐ Other: _____

Smoking/Tobacco Use: ☐Current ☐Past ☐Never Type: _____ Amount/day: _____ Number of Years _____
Alcohol: ☐Current ☐Past ☐Never Drinks/Week: _____
Recreational Drug Use: ☐Current ☐Past ☐Never Type: _____
Are you sexually active? ☐ Yes ☐ No
Comments (Please feel free to comment on any answers marked "yes" above):
_____

_____

FAMILY HISTORY:

FATHER: Living: Age_____ Deceased: Age_____

Alcoholism	Bipolar	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia/Alzheimer's	Heart Disease	Migraines	

Other: _____

MOTHER: Living: Age_____ Deceased: Age_____

Alcoholism	Bipolar	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia/Alzheimer's	Heart Disease	Migraines	

Other: _____

SIBLINGS:

_____

_____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

_____

_____

Patient Signature: _____ Date: _____