PATIENT INTAKE FORM

SECTION A: Personal Identification Data **Today's Date: _____**

FULL NAME: _____
DATE OF BIRTH: _____ AGE: _____

CONTACT INFORMATION:
ADDRESS: _____
_____
_____
Email: _____

Can we Leave messages on your voicemail?
Cell: _____ O Yes O No
Home: _____ O Yes O No

Do you consent to non-secure email communication?
O Yes O No

Who can we contact in case of an emergency?
Name: _____
Phone: _____
Relationship: _____

Do you have a family doctor that is actively involved in your care? O Yes O No

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Please Request a "transfer of records" form if you would like us to request your medical records from your previous physician (s)

Pharmacy (if you take more than 2 regular medications): Name/location_____ Phone_____

SectionB: Medical Data

Medical problem:
1. _____
2. _____
3. _____
4. _____
5. _____

MEDICATIONS:

NAME	DOSAGE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SURGERIES: _____ ALLERGIES TO MEDICATION_____ REACTION_____

CIGARETTE SMOKING:
O YES O NO #CIG/Day ___ How many years? ____
ALCOHOL
O Yes O No Drinks/wk _____

FEMALE ONLY:
Any Pregnancies? _____
Last PAP Smear year? _____
Any ABONORMAL Pap smear? O Yes O No

FAMILY MEDICAL HISTORY:
Please describe if any major medical illness run in your Family (ie: Cancer/Diabetes)

MOTHER: _____
FATHER: _____
SIBLINGS: _____
OTHER: _____

OPTIONAL ADDITIONAL INFORMATION;
EDUCATION: _____

OCCUPATION: _____