Today's Date:__________

New Patient Intake Form

Name: ____________________________________ **Date of Birth**:________________

Reason for Visit:_____________________________ **Former Physician:** _______________

Medical History: please check any problems that you have or have had in the past

Abnormal Pap Smear	☐	COPD	☐	Osteoporosis	☐
Acne	☐	Frequent UTI's	☐	Positive TB test	☐
ADD/ADHD	☐	Sinus Infections	☐	Prostate problems	☐
Alcohol Abuse	☐	Gallstones	☐	Psoriasis	☐
Anemia	☐	Glaucoma	☐	Reflux (heartburn)	☐
Anxiety	☐	Gout	☐	Rheumatoid Arthritis	☐
Asthma	☐	Heart Attack	☐	Rosacea	☐
Bipolar Disorder	☐	Heart Condition	________	Seasonal Allergies	☐
Blood Clots	☐	Hepatitis (A,B,C)	________	Seizures	☐
Blood Transfusion	☐	Hypertension	☐	STD's	☐
Cancer (what kind)	__________	High Cholesterol	☐	Stomach Ulcers	☐
Crohn's Disease	☐	IBS	☐	Stroke	☐
Colon Polyps	☐	Kidney Disease	☐	Tuberculosis	☐
Depression	☐	Kidney Stones	☐	Ulcerative Colitis	☐
Diabetes	☐	Lupus	☐	Warts	☐
Diverticulitis	☐	Skin Cancer (Type)	________	Other: _______________	
Drug Abuse	☐	Migraines	☐	______________________	
Eating Disorder	☐	Osteoarthritis	☐	______________________	
Eczema	☐	Osteopenia	☐		

Hospitalizations

Reason/Date:____

Surgeries		**Date**			**Date**
Appendectomy	☐	___________	Vasectomy	☐	____________
Arthroscopy	☐	___________	Mastectomy (R) (L)	☐	____________
Back Surgery (location)	☐	___________	Lumpectomy (R) (L)	☐	____________
Cataract	☐	___________	Tonsillectomy/Adenoids	☐	____________
Gallbladder	☐	___________	Polyp Removal (Colon)	☐	____________
Heart Surgery (specify)	☐	___________	Neck Surgery	☐	____________
Hernia	☐	___________	Plastic Surgery (specify)	☐	____________
Hysterectomy (specify)	☐	___________	Hemorrhoids	☐	____________
Knee Replacement (specify)	☐	___________	Tubal Ligation	☐	____________
Hip Replacment (R) (L)	☐	___________			

Medications (please include over the counter medication and food supplements)

Drug Name:	Dose:	How Often:
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________

Preferred Pharmacy: ____

Allergies

Drug Name:	Reaction:
______________	______________
______________	______________
______________	______________

Women:

Last Pap: __________	Age of First Period_______	# of pregnancies: ____
Last Mammogram: __________	# of days in cycle ________	# of live births: ______
Last Bone Density: __________	# of days in flow __________	# of miscarriages: ____
Last Menstrual Period: ________	Are you Menopausal: Yes or No	# of abortions: ______
	Age at onset of Menopause: ____	# of living children: ___

Family History:

Mother (M): Alive/Deceased, cause of death (if applicable): ______________________________

Father (F): Alive/Deceased, cause of death (if applicable): ______________________________

Siblings: # of Sisters _____________ # of Brothers _______________

Condition:	M	F	S	B
Heart Disease:				
Heart Attack:				
Diabetes:				
High Blood Pressure:				
High Cholesterol:				
Thyroid Disease:				
Depression:				
Other Mental Illness:				
Alcoholism:				
Drug Addiction:				
Osteoporosis:				
Migraines:				
Breast Cancer:				

	M	F	S	B
Colon Cancer:				
Prostate Cancer:				
Lung Cancer:				
Ovarian Cancer:				
Uterine Cancer:				
Skin Cancer:				
Other Cancer (specify):				

Other: ______________________________

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