Health History Intake Form

Date: _____

Patient Name: _____ **DOB:** _____**Age:** _____ **Sex:** □ **M** or □ **F**

Previous Primary Care Provider (if any): _____

Address: _____**Phone:** _____

Other Providers involved in your care: _____

Reason for visit today: _____

Allergies: (Medication/Food, indicate reaction) □ None

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Medication List: (Please list name/dose/frequency if known) □ None

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Family History: (please indicate all medical issues)

Father Age: _____ □ Alive □ Deceased

Health Problems: _____

Mother Age: _____ □ Alive □ Deceased

Health Problems: _____

Siblings Brother(s) #____ Sister(s) #____

Health Problems: _____

Grandfather Age: _____ □ Alive □ Deceased

Health Problems: _____

Grandmother Age: _____ □ Alive □ Deceased

Health Problems: _____

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Habits:

Alcohol: □ None □ Yes: Type: _____

How many drinks/day: _____/_____ frequency/week: _____/_____ Last use: _____

Tobacco: □ None □ Yes: □ Chew □ Smoke

How many/day: _____/_____ frequency/week: _____/_____ Last use: _____

Caffeine: □ None □ Yes: Type: _____

How many/day: _____/_____Last use: _____

Other Recreational Drugs: □ None □ Yes Type: _____

How many/day: _____/_____Last use: _____

Do you drive: □ Yes □ No **Do you always wear a seatbelt:** □ Yes □ No

Do you exercise: □ Yes □ No If yes, how much: _____

Social History:

Work: □ Employed □ Unemployed □ Retired □ Disabled

Current Occupation: _____ **Former Occupation:** _____

Marital Status: □ Married □ Single □ Divorced □ Domestic Partner

Sexual preference: □ Men □ Women □ Both

Children: Son(s) #_____ Ages: _____ Daughter(s) #_____ Ages: _____

Hobbies: _____

Sports: _____

Pets: _____

Other: _____

Preventive Screenings & Care:

	Yes	No	Date	Where
Mammogram	□ Yes	□ No		
Pap Smear	□ Yes	□ No		
Prostate Exam	□ Yes	□ No		
Influenza Vaccine	□ Yes	□ No		
Pneumonia Vaccine	□ Yes	□ No		
Shingles Vaccine	□ Yes	□ No		
Tetanus Vaccine	□ Yes	□ No		
Other:	□ Yes	□ No		
Other:	□ Yes	□ No		

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Past Surgical History: (indicate date if known) □ None

	Date		Date		Date
□ Cataracts:		□ Heart Valve		□ Prostate surgery/resection	
□ LASIK:		□ Gall Bladder		□ C-Section	
□ Tonsillectomy:		□ Bariatric surgery		□ Orthopedic/joints	
□ Thyroidectomy:		□ Endoscopy		□ Appendectomy	
□ Adenoidectomy:		□ Colonoscopy		□ Bowel/Stomach Resection	
□ Coronary Bypass:		□ Hernia		□ Hemorrhoidectomy	
□ Cardiac Stents:		□ Spinal Surgery		□ Other	
□ Pacemaker:		□ Bladder surgery		□ Other	

Past Medical History:

	Yes	No	Date		Yes	No	Date
Head Aches	□ Yes	□ No		Urinary Tract Infections	□ Yes	□ No	
Stroke	□ Yes	□ No		Incontinence	□ Yes	□ No	
Seizures	□ Yes	□ No		Kidney Stones	□ Yes	□ No	
Pneumonia	□ Yes	□ No		COPD (Emphysema, Bronchitis)	□ Yes	□ No	
Diabetes (Type 1 or Type 2)	□ Yes	□ No		Asthma	□ Yes	□ No	
Thyroid Disease (Low or High)	□ Yes	□ No		Depression	□ Yes	□ No	
Glaucoma	□ Yes	□ No		Bipolar Disorder	□ Yes	□ No	
Blurred Vision	□ Yes	□ No		Anxiety	□ Yes	□ No	
Hearing Loss	□ Yes	□ No		Fibromyalgia	□ Yes	□ No	
High Blood Pressure	□ Yes	□ No		Chronic Fatigue Syndrome	□ Yes	□ No	
Blood Clots	□ Yes	□ No		Arthritis	□ Yes	□ No	
Pulm Emboli (lung clots)	□ Yes	□ No		Gout	□ Yes	□ No	
DVT (leg clots)	□ Yes	□ No		Osteoporosis	□ Yes	□ No	
Heart Burn, Reflux	□ Yes	□ No		Prostate Disease	□ Yes	□ No	
Stomach Ulcers	□ Yes	□ No		Breast Disease	□ Yes	□ No	
Heart Disease	□ Yes	□ No		Erectile Dysfunction	□ Yes	□ No	
Coronary Disease	□ Yes	□ No		Menopausal Disorder	□ Yes	□ No	
MI/heart attacks	□ Yes	□ No		Cancer	□ Yes	□ No	
Congestive Heart Failure	□ Yes	□ No		Cancer Type:			
Atrial Fibrillation	□ Yes	□ No					
Angina	□ Yes	□ No					
Valve Disorder	□ Yes	□ No		Other Illness:			
High Cholesterol	□ Yes	□ No					
Gastrointestinal Bleeding	□ Yes	□ No					
Hepatitis (A, B, C)	□ Yes	□ No					

I certify that the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to a patient's health. I will not hold my provider or any members of his/her team responsible for errors or omissions that I have made in completion of this form. It is my responsibility to notify my provider of any changes in the above medical status.

Patient or Responsible Party Signature: _____ Date: _____

Print Name Patient or Responsible Party: _____