General Medical Intake for NEW patient

Date: ______________ Name: ______________________ DOB: ____________________

How did you hear about our office? ____________________

Reason for your visit today: ____

Allergies:

	Medication	Reaction
1.		
2.		
3.		
4.		

	Medications	Dose	Frequency	Estimated date of initiation
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

	Medical Condition	Estimated date of diagnosis
1.		
2.		

3.___

4.___

5.___

	Surgery	What year?	Which Hospital?
1.			
2.			
3.			
4.			
5.			

For Women: Last pap smear: ___ Where was it done: ___

Last mammogram: ___ Where was it done: ___

For Both Sexes: Last Colonoscopy: ___ Where was it done: ___

If you have Diabetes:

Date of last eye examination: ___ Ophthalmologist Name: ___

<u>Social History:</u>

Caffeinated Beverages: Type (coffee, tea, soda, etc.) ___ Amount ___ Frequency ___

Alcohol: Type (liquor, wine, beer, etc.) ___ Amount ___ Frequency ___

Smoking Status: Current ________ Amount & Frequency ______________ ____________ Start Year _________ End Year ________

Exercise: Type ___________________________ Intensity _________ Frequency __________

Family History:

List medical illnesses & cause of death

Mother:____

Father:____

Brother/Sister:____

____

Spouse:____

Children:____

____

Completed by:____________________________________ **Date:**_________________________________

Patient Signature: ____

Reviewed by: _________________________________ Date:____________________________________