NEW PATIENT INTAKE FORM

DATE: **DOCTOR:**

FULL NAME:

DATE OF BIRTH (DAY/MONTH/YEAR:

ADDRESS:

PHONE NUMBER: (H): **(C):**

WHICH CONTACT NUMBER IS PREFERRED?

MAY WE LEAVE MEDICAL MESSAGES?

EMAIL ADDRESS:

DO YOU GIVE PERMISSION FOR EMAIL TRANSMISSION OF REQUISITIONS, REPORTS ETC?

HEALTH CARD NUMBER: **VERSION CODE:**

HEALTH CARD EXPIRY DATE:

EXTENDED HEALTH BENEFIT PLAN: YES o NO o

IF YES, WHO IS THE PROVIDER?

WHO WAS YOUR PREVIOUS FAMILY PHYSICIAN?

REASON FOR LEAVING THE PRACTICE:

ALLERGIES TO MEDICAITONS:

MEDICATION	REACTION

OTHER ALLERGIES:

HAS A COPY OF YOUR IMMUNIZATION RECORD BEEN PROVIDED TO THE OFFICE?

IF OVER THE AGE OF 65, HAVE YOU HAD THE FOLLOWING VACCINES:

Zostavax o Pneumovax o Tetanus o Prevnar o

MEDICATIONS:

- o NONE
- o I PRESENTLY TAKE THE FOLLOWING (INCLUDE OVER THE COUNTER MEDICATIONS)

NAME OF MEDICATION	AMOUNT PER DAY	REASON

PAST MEDICAL HISTORY:

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

CNS	**CARDIOVASCULAR**	**RESPIRATORY**
o Y o N – CEREBRAL ANEURYSM o Y o N – STROKE o Y o N – BRAIN TREMOR o Y o N – SEIZURE DISORDER o Y o N – NEUROPATHY o Y o N – MS/MD	o Y o N – HYPERTENSION o Y o N – HIGH CHOLESTEROL o Y o N – VALVE DISEASE o Y o N – HEART ATTACK o Y o N – IRREGULAR HEARTBEAT o Y o N - PACEMAKER	o Y o N – ASTHMA o Y o N – COPD o Y o N – BRONCHITIS o Y o N – TUMORS
GASTROINTESTINAL	**GENITOURINARY**	**PSYCHITRIC**
o Y o N – HIATAL HERNIA o Y o N – ULCER o Y o N – CHRON'S DISEASE o Y o N – COLON POLYPS o Y o N – ULCERATIVE COLITIS o Y o N – BARRETT'S DISEASE o Y o N – REFLUX/HEARTBURN	o Y o N – KIDNEY DISEASE o Y o N – OVERACTIVE BLADDER/LEAKING o Y o N – STDS (if yes, which? o Y o N – BENIGN PROSTATE HYPERTROPHY o Y o N – ARE YOU PREGNANT?	o Y o N – DEPRESSION o Y o N – ANXIETY o Y o N – BIPOLAR o Y o N – SCHIZOPHRENIA o Y o N – PTSD o Y o N – DEMENTIA/ALZHEIMER'S
BONE/MUSCLE	**INFECTIOUS/CANCER**	**METABOLIC**
o Y o N – ARTHRITIS o Y o N – FIBROMYALGIA o Y o N – OSTEOPOROSIS o Y o N – CHRONIC PAIN	o Y o N – HEPATITIS o Y o N – AIDS o Y o N – TUBERCULOSIS o Y o N – CANCER	o Y o N – LIVER DISEASE o Y o N – DIABETES o Y o N – HYPERTHYROID o Y o N – HYPOTHYROID o Y o N – BLEEDING DISORDER Type: o Y o N – OVERWEIGHT

ANY OTHER SIGNIFICANT MEDICAL CONDITIONS?

SURGICAL HISTORY: (Please list type and date)

FRACTURES/BROKEN BONES: (Please list type and date)

FAMILY HISTORY
Please list family members and any significant illness/diseases they may have.
Please document here if you are adopted.

SOCIAL HISTORY

OCCUPATION:
MARTIAL STATUS: MARRIED o SINGLE o WIDOWED o DIVORCED o
CHILDREN/GRANDCHILDREN: o Y o N
HOW MANY?
WHO LIVES AT HOME WITH YOU?

SMOKING: o NONE o CURRENT o EX-SMOKER
PACKS PER DAY: **HOW MANY YEARS?**
AT WHAT AGE DID YOU START? **WHAT AGE DID YOU STOP?**

ALCOHOL:
HOW MANY DRINKS PER WEEK?
DO YOU HAVE A HISTORY OF ALCOHOL ABUSE?

DRUGS: o NEVER o OCCASIONALLY o FREQUENTLY
WHAT KIND?
INTRAVENOUS DRUG USE? o Y o N

PREVENTATIVE HEALTHCARE

HAVE YOU HAD ANY OF THE FOLLOWING PROCEDURES DONE:
o Y o N PAP – If yes, when and what were the results?
o Y o N FIT – If yes, when and what were the results?
o Y o N Colonoscopy – If yes, when and what were the results?
o Y o N BONE MINERALY DENSITY SCREEN – If yes, when and what were the results?
o Y o N Mammogram – If yes, when and what were the results?
o Y o N Ultrasound of Aorta – If yes, when and what were the results?

CURRENT HEALTH ISSUES OR THINGS YOU WOULD LIKE THE DISCUSS WITH THE PHYSICIAN?