New Patient Intake Form

Patient name: _____ DOB:_____

Address: _____

Phone number: _____ Email: _____

Emergency Contact (name, relationship, phone number):

_____

Previous Primary Care Doctor: _____

Other Doctors: _____

_____

_____

Past Medical History: (list all previous diagnoses)

Diagnosis	Age

Diagnosis	Age

Past Surgeries:

Surgery	Date or Age

Current Medications: (Please include over the counter and supplements)

Medication	Dose	Frequency

Allergies: (please list reaction)

_____

_____

_____

_____

Family History:

Diagnosis	Relationship (e.g parent, grandparent, sibling)
Coronary Artery Disease	
Stroke	
Diabetes	
High Blood Pressure	
Cancer (type)	
Other:	

Social History:

Alcohol use:	**Yes**	How many drinks per week?_____ Drink of choice _____	**No**
Tobacco use:	**Yes**	Packs per day _____ Age started _____ Age quit _____	**No**
Drug use:	**Yes**		**No**
	Drug	_____	
Caffeine use:	**Yes**	Drinks per day _____	**No**

Exercise Habits: Days per week _____ How many minutes _____

Single Married Divorced Widowed Other: _____

Vaccination history:

Vaccination	Date or Age
Pneumonia	
Shingles	
Tetanus	
Pertussis	
Covid-19	
Influenza	
Other:	

Screening Exams:

Exam	Date or Age	Normal/Abdnormal
Colonoscopy		
Pap smear		
Mammogram		
DEXA Scan (bone density)		
Prostate Exam or PSA		
Lung Cancer		
Cardiac Stress Test		
Cardiac Cath		
Other:		