

Medical Intake Form

PATIENT NAME: _____ DOB: _____ EMAIL: _____

REASON FOR VISIT: _____

PHARMACY NAME AND ADDRESS: _____

PLEASE PROVIDE A COPY OF YOUR MEDICATIONS INCLUDING DOSAGE AND FREQUENCY OR LIST HERE:

PLEASE USE BACK OF FORM IF MORE ROOM IS NEEDED

PLEASE LIST ANY ALLERGIES: _____

PATIENT MEDICAL HISTORY: (CIRCLE ALL THAT APPLY)

- | | | | | |
|--------------------|--------------|----------------|----------------------|-----------------|
| HEART DISEASE | HYPERTENSION | HYPOTENSION | HYPERCHOLESTEROLEMIA | HYPERLIPIDEMIA |
| SEIZURES | STROKE | DIABETES | CANCER | MAJOR INFECTION |
| ASTHMA | LUNG DISEASE | KIDNEY DISEASE | THYROID DISEASE | HEPATITIS |
| MIGRAINE HEADACHES | ARTHRITIS | ANEMIA | TUBERCULOSIS | HIV |
| GLAUCOMA | BACK TROUBLE | DEPRESSION | ANXIETY | ULCERS |

LIST ANY OTHER DISEASES: _____

FAMILY HISTORY: (CIRCLE STATUS AND CHECK ALL THAT APPLY)

	Status	Age	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Migraine	Unknown
Father	Alive / Deceased								
Mother	Alive / Deceased								
Brother	Alive / Deceased								
Sister	Alive / Deceased								
Son	Alive / Deceased								
Daughter	Alive / Deceased								

SURGICAL HISTORY: (LIST PROCEDURE AND DATE)

SOCIAL HISTORY:

- TOBACCO USE: NEVER PREVIOUSLY BUT QUIT YES PACKS/DAY _____
- USE OF ALCOHOL: NEVER PREVIOUSLY BUT QUIT YES AMOUNT _____
- USE OF "RECREATIONAL DRUGS": NEVER PREVIOUSLY BUT QUIT YES WHAT? _____

Work History: ___ Employed ___ Unemployed ___ Disabled ___ Retired