# New Patient Intake Form

Patient Name__________________________ Date of Birth ______________ Today's Date _____________

## SOCIAL HISTORY

Who lives at home with you?__________________________________________________________________

Birthplace___________________________ Education/Degree Level _______________________________

Employer ____________________________ Occupation (Full time/Part time)_________________________

## LIFESTYLE CHOICES

**Exercise**

Type______________________ Times per week______________ Duration____________

Special Diet ☐ Vegetarian ☐ Vegan ☐ Other ___________________________________________________

Caffeine ☐ Soda ☐ Coffee ☐ Tea Drinks Per Day_________

Weight Now_________ 1 Year Ago_________ Desired_________

**Tobacco**

Do you smoke? ☐ Yes ☐ No ☐ Quit Do you use smokeless tobacco? ☐ Yes ☐ No ☐ Quit

How many years? ________

How many packs/cans per day? ________

Are you ready to quit? ☐ Yes ☐ No

If you quit using tobacco, when did you stop? ________

**Alcohol**

Do you consume alcohol? ☐ Yes ☐ No ☐ Quit

How many drinks containing alcohol do you consume in a week? ________
(1 drink = 1 glass of wine = 1 beer = 1 shot of liquor)

## MEDICATIONS, VITAMINS, SUPPLEMENTS

Check the following non-prescription items that you use:

☐ Acetaminophen (Tylenol)
☐ Allergy Pills
☐ Antacids
☐ Aspirin
☐ Decongestants
☐Ibuprofen (Advil, Motrin)
☐ Laxatives
☐ Nasal Spray
☐Supplements
☐ Naproxen (Aleve)
☐ Natural Hormones
☐ Vitamins (Please List) ______________________________________________________
☐ Herbs (Please List) _________________________________________________________
☐ Other (Please List) _________________________________________________________

**Please check the boxes to indicate if you have had any of these conditions:**

| | | |
|---|---|---|
| ☐ NONE | ☐ Cirrhosis | ☐ Kidney Stones |
| ☐ Abnormal Pap | ☐ Colon Cancer | ☐ Memory Loss |
| ☐ Alcohol Abuse | ☐ COPD / Emphysema | ☐ Migraine/Headaches |
| ☐ Allergies, Seasonal | ☐ Crohn's Disease | ☐ Osteoporosis |
| ☐ Anemia | ☐ Depression | ☐ Peripheral Artery Disease |
| ☐ Anxiety | ☐ Diabetes | ☐ Prostate Cancer |
| ☐ Arthritis | ☐ Diverticulitis | ☐ Prostate Problem |
| ☐ Asthma | ☐ Glaucoma | ☐ Reflux or GERD |
| ☐ Autoimmune Disorder | ☐ Hearing Loss | ☐Seizure Disorder |
| ☐ Bleeding Disorder | ☐ Heart Attack | ☐ Skin Cancer |
| ☐ Blood Transfusions | ☐ Hepatitis | ☐ Stroke |
| ☐Blood Clots / DVT | ☐ High Cholesterol | ☐ Thyroid Problem |
| ☐ Breast Cancer | ☐ High Blood Pressure | ☐ Transient Ischemic Attack |
| ☐ Breast Lump | ☐ HIV | ☐ Ulcers of Stomach |
| ☐ Carotid Artery Disease | ☐ Irregular Heartbeat | ☐ UTIs - Recurrent |
| ☐ Cataracts | ☐ IV Drug Use | ☐ Valve Problem/Murmur |
| ☐ Cervical Cancer | ☐ Kidney Disease | ☐ Varicose Veins/Phlebitis |

Please list any other medical condition(s) that you have now or have had in the past:

______________________________________________________________________________

______________________________________________________________________________

Please list your prescription medications:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Please list allergies:

______________________________________________________________________________

______________________________________________________________________________

Please list surgical history:

______________________________________________________________________________

______________________________________________________________________________

PREVENTIVE SERVICES

Please list the **date, location, and specialist name** you last had these services or tests:

Physical Examination ____________________ Tetanus ____________________________

Pap Smear ___________________________ Shingrix (Shingles) _____________________

Colonoscopy ___________________________ Pneumonia _________________________

Prostate Check___________________________ HPV _________________________

Bone Density ___________________________ Influenza Vaccine _____________________

Dentist Visit _____________________________ Eye Exam_____________________________

## ACCIDENT / TRAUMA / MENTAL HEALTH

Do you wear helmets with biking/skating? Yes___ No___ Not Applicable___

Do you have smoke detectors? Yes___ No___ If yes, are they in working order? Yes___ No___

Do you have handguns? Yes ___ No___ If yes, are they secured? Yes ___ No___

Do you wear seatbelts? Yes___ No___ If yes, is it 100% of the time? Yes___ No___

Do you drink and drive? Yes___ No___

Do you participate in extreme sports? Yes___ No___ If yes, do you wear protective gear? Yes___ No___

Do you feel safe at home? Yes___ No___

## PHQ-2

| Over the past 2 weeks, how often have you been bothered by any of the following problems? | Not at All | Several Days | More than half the Days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | | | | |
| 2. Feeling down, depressed, or hopeless | | | | |

## FALL RISK

In the past year have you had more than 2 falls? Yes___ No___
If yes, how many?_________
Did the falls result in injury? Yes___ No___

## FAMILY HISTORY

Tell us about your **immediate family** members: ☐ Check here if you were ADOPTED

| Family Member | Birth Year | Medical Status | Age at Death | Cause |
|---|---|---|---|---|
| Father | | | | |
| Mother | | | | |
| 1.Brother/Sister (circle one) | | | | |
| 2.Brother/Sister | | | | |
| 3.Brother/Sister | | | | |
| Spouse | | | | |
| 1.Son/Daughter (circle one) | | | | |
| 2.Son/Daughter | | | | |
| 3.Son/Daughter | | | | |

## MENSTRUAL HISTORY

First date of last period ____________________ If menopausal, age at last period _________________
Period irregular? ☐Yes ☐No How many pregnancies? ______ Number of children born alive ________
Birth Control ☐Pills ☐Condoms ☐IUD ☐Surgery ☐ Other ______________