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New Patient Intake Form

Please complete this form **prior** to your first appointment.

Contact Information

First Name: _____ Last Name: _____
Date of Birth: _____ Sex: ☐Male ☐Female Social Security #: _____
Physical Address: _____ Apt#: _____
City: _____ State: _____ Zip: _____
Phone#: Cell: _____ Home: _____ Work: _____
Preferred method of contact? ☐ Cell ☐ Home ☐ Work
Email: _____
Race: ☐ American Indian/Native Alaskan ☐ Asian ☐ Black/African American
☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other
Emergency Contact: _____ Relationship: _____ Contact#: _____
Referring Doctor: _____ **Primary Care Doctor:** _____

How did you hear about us?

☐ Family/Friend ☐ Doctor ☐ Internet ☐ Insurance ☐ Newspaper
☐ Other If other, please specify: _____

Insurance Information

Please bring your insurance card and driver license with you to every visit.
Provider: _____ ID#: _____ Grp#: _____
Secondary Provider (if applicable): _____ ID#: _____ Grp#: _____

Personal Preferences & Notice of Privacy Practices

May we communicate with you by email? ☐ Yes ☐ No
May we communicate with you by voicemail? ☐ Yes ☐ No
May we communicate with you by text? ☐ Yes ☐ No

MEDICAL HISTORY FORM

PHARMACY: _____ LOCATION: _____

What brings you to our office today?:

_____

_____

Current Medications (Include name, dosage, and frequency):

_____

_____

_____

_____

***Please bring a complete list of medications to each office visit. Include dosage and frequency as well as name.

Medical History:

Diabetes	No	Yes	Elevated Cholesterol	No	Yes
Cancer (Type: _____)	No	Yes	Hypertension	No	Yes
Heart Trouble	No	Yes	Stroke	No	Yes
Convulsions/Seizures	No	Yes	Arthritis/Gout	No	Yes
Acute Infection	No	Yes	Bleeding Tendency	No	Yes
Hereditary Defects	No	Yes	Crohn's Disease	No	Yes
Diverticulitis	No	Yes	Ulcerative Colitis	No	Yes
Ulcer Disease	No	Yes	Lung Disease	No	Yes
Diarrhea	No	Yes	Liver Disease	No	Yes
Constipation	No	Yes	Colon Polyps	No	Yes
Thyroid Disease	No	Yes	Dementia	No	Yes

Additional Medical Problems Not Listed:

_____

_____

_____

Allergies: ☐ NO KNOWN ALLERGIES

_____

_____

Surgeries:

_____

_____

Recent Hospitalizations:

_____

_____

Family History of gastrointestinal disorders or cancers:

	Age:	Circle One:	Gastrointestinal disease(s) or cancer(s):
Father:	____	Living / Deceased	_____
Mother:	____	Living / Deceased	_____
Sibling:	____	Living / Deceased	_____
Sibling:	____	Living / Deceased	_____
Sibling:	____	Living / Deceased	_____

Social History

Alcohol Use

Did you have a drink containing alcohol in the past year?

- ☐ Yes
- ☐ No

If Yes: How often did you have a drink containing alcohol in the past year?

- ☐ Monthly or less
- ☐ 2 to 4 times a month
- ☐ 2 to 3 times a week
- ☐ 4 or more times a week

If Yes: How many drinks did you have a typical day when you were drinking in the past year?

- ☐ 1 or 2 drinks
- ☐ 3 or 4 drinks
- ☐ 5 or 6 drinks
- ☐ 7 to 9 drinks
- ☐ 10 or more drinks

If Yes: How often did you have 6 or more drinks on one occasion in the past year?

- ☐ Never
- ☐ Less than monthly
- ☐ Weekly
- ☐ Daily or almost daily

Smoking/Tobacco Use

Are you a

- ☐ current smoker
- ☐ former smoker
- ☐ nonsmoker
- ☐ current tobacco user

If current smoker: How often do you smoke cigarettes?

- ☐ every day
- ☐ some days, but not every day

If current smoker: How many cigarettes do you smoke in a day?

- ☐ 5 or less
- ☐ 6-10
- ☐ 11-20
- ☐ 21-30
- ☐ 31 or 39
- ☐ 40 or more

If current smoker: How soon after you wake up do you smoke your first cigarette?

- ☐ within 5 minutes
- ☐ 6-30 minutes
- ☐ 31-60 minutes
- ☐ after 60 minutes

If current smoker: Are you interested in quitting?

- ☐ Ready to quit
- ☐ Thinking about quitting
- ☐ Not ready to quit

Drug Use

Have you used any drugs other than those for medical reasons in the past 12 months?

☐ Yes (Type: _____) ☐ Former User ☐ No

REVIEW OF SYSTEMS

Constitutional Symptoms

Good general health lately	No	Yes
Recent weight change? ☐ loss ☐ gain	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headache	No	Yes

Ears/Nose/Throat/Mouth

Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Chronic sinus problems or sinusitis	No	Yes
Nose bleeds	No	Yes
Mouth Sores	No	Yes
Bleeding gums	No	Yes
Bad breath or bad taste	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

Cardiovascular

Heart trouble	No	Yes
Chest pain or angina pectoris	No	Yes
Palpitation	No	Yes
Shortness of breath when walking/lying flat	No	Yes
Swelling of feet, ankles, or hands	No	Yes

Respiratory

Chronic or frequent cough	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes

Gastrointestinal

Loss of appetite	No	Yes
Change in bowel habits	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Painful bowel movements	No	Yes
Rectal bleeding or blood in stool	No	Yes
Abdominal pain or heartburn or peptic ulcer (stomach or duodenal)	No	Yes

Neurological

Frequent or recurring headaches	No	Yes
Lightheaded or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Stroke	No	Yes
Head injury	No	Yes

Psychiatric

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

Endocrine

Glandular or hormone problems	No	Yes
Thyroid Disease	No	Yes
Diabetes	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Skin becoming dryer	No	Yes
Change in hat or glove size	No	Yes

Hematological/Lymphatic

Slow to heal after cuts	No	Yes
Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusions	No	Yes
Enlarged glands	No	Yes