Wellness Family Medicine: New Patient Intake Form

Legal Name: _____ DOB: _____ Date: _____

MEDICAL HISTORY Please check all that apply: *Pulmonary* o Emphysema o Pneumonia o Bronchitis o Asthma

Cardiovascular o Stroke o High Blood Pressure o Elevated Cholesterol o heart attack o stroke

Endocrine: Diabetes If yes, how long _____and how much did you weigh at diagnosis_____

GI: o Hepatitis A or B o Hepatitis C o Cirrhosis o Gallbladder Disease o Ulcers o surgery _____

GU: o Frequent urination/Bladder Infections o Sexually Transmitted Infections o Prostate Trouble

Orhtopedic: o Arthritis o Osteoporosis o Fractures o Low back pain o Surgeries _____

Neuro/Psych o Migraines o Depression o Anxiety or Panic Disorder o Post-traumatic Stress Disorder o Alcohol or Substance Use Problem o Other: _____

SYSTEMS REVIEW *General*: o Recent: weight loss o weight gain o Fatigue o Fever o Night sweats

Skin: o Rashes o Lumps o Itching o Dryness o Color changes o Hair and Nail changes o skin cancer

Head: o Headaches o Head Injuries o Dizziness

Eyes: Date of Last Eye Exam: _____ o Eye pain o Double vision o Glaucoma o Cataracts o

ENT: o Frequent Colds o Nasal stuffiness o Hay fever o Nosebleeds o Sinus trouble o Allergies: dust/animal/seasonal Ears: o Hearing loss o Ear pain o Ringing in the ear Mouth and Throat:

Heart: o chest pain o rhythm problems o abnormal heart valve o High blood pressure o poor circulation

Respiratory: o chronic cough o shortness of breath o wheezing

GI: o change in bowel movements o blood per rectum o nausea o vomiting

Urinary: o frequent bladder infections o nighttime urination o incontinence

Ortho: o arthritis o joint pain requiring medicine o calf pain with walking

Neuro: o TIA or stroke in past o memory loss o recent numbness or weakness o history of seizure

Heme/Lymph: o bleeding tendencies/bruising o history of anemia o fluid accumulation in arms/legs

Breasts: o pain o discharge o other changes or abnormalities.

Smoking: o yes. O no If yes, how many packs per day _____. How many years _____

Alcohol: o yes o no. If yes, how many drinks/wk _____ preferred type of alcohol _____

Family History: What medical problems do/did your mother and father have?

Medications: Please list Rx and over the counter meds on back of this form. Include writing MD/NP