



Intake Form

Name _____ Today's Date: _____
Date of Birth _____ Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
E mail address _____ Preferred means of Contact _____
Emergency Contact: _____ Phone _____
Occupation/Employer _____ SSN _____

Pharmacy/location or phone number _____
How did you hear about All In Family Med? _____

Primary Insurance _____ ID Number _____
Group Number _____ Phone Number _____
Insured Person Details If Not Self: Name _____ DOB _____

Secondary Insurance _____ ID Number _____
Group Number _____ Phone Number _____
Insured Person Details If Not Self: Name _____ DOB _____

CURRENT PCP-Name and location: _____

Medical History: Prior Diagnoses (Circle all that are Appropriate)

- AIDS & HIV High Blood Pressure Epilepsy
Chicken Pox CHF Migraine Headache.
Diphtheria Low Blood Pressure Stroke
Hepatitis Mitral Valve Prolapse Glaucoma
Infectious Mono High Cholesterol Kidney Disease/Failure
Measles DVT Asthma
Mumps PE Bronchitis
Pneumonia Diabetes Depression
Polio Thyroid Disease Anxiety
Rheumatic Fever Frequent Diarrhea Other Mental illness
Scarlet Fever Gallbladder Dz
Small pox Heartburn
Tuberculosis Hemorrhoids Drug Addiction
Sexually transmitted infection _____ Hernia _____
Whooping Cough Ulcer Alcohol Addiction
Cancer _____ IBS _____
Anemia Crohn Eating Disorder
Bleeding Tendency Lupus Prior suicide attempt
Blood Plasma Transfusion MS Infertility
CVA or Stroke Seizure disorder Bladder Infection
Chest Pain/Angina... Hives or Eczema PCOS
Heart Attack Acne endometriosis
Heart Murmur Arthritis uterine fibroid
Back Trouble abnormal Pap smear
Loss of Urine



Prostate hypertrophy
Osteoporosis
Fracture _____

Date of Last Chest X-Ray _____
Any Other Disease
List: _____

Past Hospitalizations/Surgeries (age or Year)

Appendix removed _____
Breast Surgery _____
Tubal Ligation _____
Cesarean Section _____
Gallbladder _____
D&C _____
Weight Loss _____
Heart Surgery _____

Hernia Repair _____
Liver Biopsy _____
Prostate _____
Hysterectomy (Uterus removed) _____
Uterus, tubes, ovaries removed _____

Other surgery on uterus, tubes, or ovaries _____
Cosmetic surgery _____
Other: _____

Family Medical History and Family Members with illness

AIDS & HIV _____
Pneumonia _____
Tuberculosis _____
Cancer _____

Anemia _____
Bleeding Tendency _____

CVA or Stroke _____
Chest Pain/Angina _____
Heart Attack _____
Heart Murmur _____
High Blood Pressure _____

CHF _____
Low Blood Pressure _____
Mitral Valve Prolapse _____
High Cholesterol _____

DVT _____
PE _____
Diabetes _____

Thyroid _____
Gallbladder _____
Heartburn _____
Hernia _____
Ulcer _____
IBS _____
Crohn _____
Lupus _____
MS _____
Seizure _____
Hives or Eczema _____
Acne _____
Arthritis _____
Back Pain _____
Migraine _____
Glaucoma _____
Kidney Disease/Failure _____

Asthma _____
Bronchitis _____
Depression _____
Anxiety _____

Other Mental illness _____

Drug Addiction _____

Alcohol Addiction _____

Eating Disorder _____
Prior suicide attempt _____

Infertility _____
PCOS _____
endometriosis _____
Prostate _____
Osteoporosis _____
Any Other Disease
List: _____

Social History:

Single
Married

Divorced
Widow/Widower

Partner

Tobacco

Never
Every day _____ PPD for _____ yrs

Former Smoker _____ years
Quit year _____

Vape/Pipe/Chew
How Much _____

Alcohol

Never

Once a Month/Socially

Once a week



2-3/week

Daily

Daily > 1 drink

Other Drugs

THC Once in while

THC daily

THC weekly

Other _____

Exercise:

Never

3-5 x week

Moderate 100-150 min/wk

Once a month

Daily

Heavy/intense >150 min/wk

Once a week

Mild (walk) 50-100 min/wk

Hobbies/Recreation: _____

SCREENING, WELLNESS AND VACCINES: (with date or year performed)

Physical exam: _____

Mammogram _____

Pneumonia 13 _____

HIV testing: _____

Echocardiogram: _____

Pneumonia 23 _____

STI testing: _____

Colonoscopy: _____

Shingles 1 _____

Labs: _____

Bone density scan: _____

Shingles 2 _____

Dental exam: _____

PSA lab test _____

Flu Shot _____

Eye exam: _____

Prostate exam _____

Covid Vaccine _____

Pap Smear _____

Tetanus/TDAP _____

LMP/ menopause: _____

Current Birth control method _____

Number of pregnancies _____ **Number of live births** _____ **Number of miscarriages/abortions** _____

Medications with doses:

Supplements:

Allergies:

Medications:

Foods:

Other (latex):

Do you feel stress - tense, restless, nervous, or anxious, or unable to sleep at night because your mind is troubled these days?

- Not at all
- Only a little
- To some extent
- Rather much
- Very much
- Patient declined to specify

Do you have meaningful connections ie: church, organizations or groups Yes/No