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
Chicken Pox
Diphtheria
Hepatitis
Infectious Mono
Measles
Mumps
Pneumonia
Polio
Rheumatic Fever
Scarlet Fever
Small pox
Tuberculosis
Sexually transmitted infection_____________________
Whooping Cough
Cancer ________________
____
Anemia
Bleeding Tendency
Blood Plasma Transfusion
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 Disease
Frequent Diarrhea
Gallbladder Dz
Heartburn
Hemorrhoids
Hernia
Ulcer
IBS
Crohn
Lupus
MS
Seizure disorder
Hives or Eczema
Acne
Hirsutism
Arthritis
Back Trouble

Epilepsy
Migraine Headache.
Stroke
Glaucoma
Kidney Disease/Failure
Asthma
Bronchitis
Depression
Anxiety
Other Mental illness
____
____
Drug Addiction
____
Alcohol Addiction
____
Eating Disorder
Prior suicide attempt
Infertility
Bladder Infection
PCOS
endometriosis
uterine fibroid
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 <u>Family Members with illness</u>

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