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 _____
Address if different from Yours _____
Secondary Insurance _____ ID Number_____
Group Number _____ Phone Number _____
Insured Person Details If Not Self: Name _____DOB _____
Address if different from Yours _____

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 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 AND WELLNESS: (Dates of last exams)

Physical exam: _____
Pap Smear _____
PPCV 23 _____
STI testing: _____
Mammogram _____
Shingles 1 _____
Labs: _____
Echocardiogram:_____
Shingles 2 _____
PSA lab test_____
Colonoscopy: _____
Flu Shot _____
Prostate exam _____
Bone density scan:_____
Covid Test _____
Dental exam: _____
TDAP _____
Last Menstrual Period/ menopause: _____
Eye exam: _____
PCV 13 _____

Current Birth control method_____

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