# Adult 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 _____
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**

- ☐ 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**

- ☐ 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
☐ Vape
☐ Pipe
☐ Chew

**Alcohol**

☐ Never
☐ Once a Month/Socially
☐ Once a week
☐ 2-3/week
☐ Daily
☐ Daily >1 drink

**Other Drugs**

☐ THC Once in while
☐ THC weekly
☐ THC daily
☐ Other _____

**SCREENING AND WELLNESS: (Dates of last exams)**

Physical exam: _____
STI testing: _____
Labs: _____
PSA lab test_____
Prostate exam _____
Dental exam: _____
Eye exam: _____

Pap Smear _____
Mammogram _____
Echocardiogram:_____
Colonoscopy: _____
Bone density scan:_____
TDAP _____
PCV 13 _____

PPCV 23 _____
Shingles 1 _____
Shingles 2 _____
Flu Shot _____
Covid Test _____

**Medications:**

_____
_____
_____

_____
_____
_____
_____

_____
_____
_____
_____

**Supplements:**

All In Family Medicine 2139 N. Academy Blvd CoSp, CO 80909 Phone 719-55-1172 Fax 719-400-4803

| | | |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Allergies:**

| Medications: | Foods: | Other (latex): |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |