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 www.pagefamilyhealthandwellness.com

MEDICAL HISTORY INTAKE FORM

Please complete all sections to assist us in providing you and your family with the best healthcare.

| | | | |
|------------------|-------------------|-----------|------------|
| Last Name | First Name | MI | DOB |
|------------------|-------------------|-----------|------------|

MEDICATIONS

List all medications you take, prescription and non-prescription and their dosage:

NO MEDICATIONS

| Medication | Dose | Times per Day |
|------------|------|---------------|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |

MEDICATION ALLERGIES

Do you have Allergies or Intolerance to medications?

If yes, to what & what reaction?

NONE

| MEDICATION | REACTION |
|------------|----------|
| | |
| | |
| | |

SURGICAL HISTORY

| TYPE (specify left/right) | DATE | LOCATION/FACILITY |
|---------------------------|------|-------------------|
| | | |
| | | |
| | | |
| | | |

SPECIALIST & OTHER PROVIDERS

| SPECIALTY | LOCATION & PHONE NUMBER |
|-----------|-------------------------|
| | |
| | |
| | |
| | |

SOCIAL HISTORY

| | | | |
|--|--|---|-------------------------|
| TOBACCO USE | Smoke Cigarettes? Y N <i>(If you never smoked, please move to Alcohol Use)</i> | | |
| <i>Current:</i> Packs/day ____ # of Years | <i>Past:</i> Quit Date: _____ Packs/day ____ # of Years | | |
| Other Tobacco <i>(check one)</i> : <input type="checkbox"/> Pipe <input type="checkbox"/> Cigar <input type="checkbox"/> Snuff <input type="checkbox"/> Chew | | | |
| ALCOHOL USE | Do you drink alcohol? Y N | <input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Liquor | # of Drinks/week: _____ |
| <i>Former:</i> Quit Date: _____ | | | |
| CAFFEINE | Do you drink caffeine? Y N | Type? _____ | Amount Daily? _____ |
| EXERCISE | Do you exercise regularly? Y N | If no, why? _____ | |
| What type of exercise? _____ | | | |

Do you give permission to receive blood transfusion if medically necessary? Yes No

What is your preferred pharmacy:

Pharmacy: _____ Phone Number: _____

Address: _____

HEALTH MAINTENANCE

Please include the date

| | | | | | |
|--------------------------|--|----------------|--------------------------|--|----------------|
| History and Physical | <input type="checkbox"/> Yes <input type="checkbox"/> No | ____/____/____ | Pulmonary Function Tests | <input type="checkbox"/> Yes <input type="checkbox"/> No | ____/____/____ |
| Stool cards/IFOBT | <input type="checkbox"/> Yes <input type="checkbox"/> No | ____/____/____ | EKG | <input type="checkbox"/> Yes <input type="checkbox"/> No | ____/____/____ |
| Colonoscopy | <input type="checkbox"/> Yes <input type="checkbox"/> No | ____/____/____ | Eye Exam | <input type="checkbox"/> Yes <input type="checkbox"/> No | ____/____/____ |
| DEXA Scan (Bone Density) | <input type="checkbox"/> Yes <input type="checkbox"/> No | ____/____/____ | Foot Exam | <input type="checkbox"/> Yes <input type="checkbox"/> No | ____/____/____ |
| Pap smear | <input type="checkbox"/> Yes <input type="checkbox"/> No | ____/____/____ | Influenza Vaccine | <input type="checkbox"/> Yes <input type="checkbox"/> No | ____/____/____ |
| Mammogram | <input type="checkbox"/> Yes <input type="checkbox"/> No | ____/____/____ | Pneumococcal Vaccine | <input type="checkbox"/> Yes <input type="checkbox"/> No | ____/____/____ |
| Cardiac Stress Test | <input type="checkbox"/> Yes <input type="checkbox"/> No | ____/____/____ | Tetanus Vaccine | <input type="checkbox"/> Yes <input type="checkbox"/> No | ____/____/____ |
| Echocardiogram | <input type="checkbox"/> Yes <input type="checkbox"/> No | ____/____/____ | | | |

Patient Signature

Date

Provider Signature

Date