**History Intake Form**

**Patient Name:**____________________________ **Date of Birth:**_______ **Age:**_______ **Gender:** ______

**Address**__________________________________________________**City:**_________________________

**Referring physician:**_________________________ **Primary care physician:**________________________

**How did you hear about us:** _______________________________________________________________

**Pharmacy:**___________________ **Occupation** ___________________ **Employer**____________________

**Emergency Contact:**_______________ **Relationship**___________________ **Phone:**__________________

**Insurance:** __________________**Copay** _______**Secondary** ______________**Primary Holder DOB:**________

**Purpose of your visit today**________________________________ **Email:** _____________________________

**Please answer all of the questions as accurately as possible. If you do not understand the question, please ask for assistance.**

**Past Medical History:**

Have you ever had the following (please **circle**):

| | | | | | |
|---|---|---|---|---|---|
| Heart attack | yes/no | Cancer | yes/no | Thyroid disease | yes/no |
| High blood pressure | yes/no | Asthma | yes/no | Anemia | yes/no |
| Irregular heartbeat | yes/no | Stomach ulcer | yes/no | AIDS/HIV+ | yes/no |
| Diabetes | yes/no | Arthritis | yes/no | Tuberculosis | yes/no |
| Stroke | yes/no | Glaucoma | yes/no | Mitral valve prolapse | yes/no |
| Kidney disease | yes/no | Depression/Anxiety | yes/no | Hepatitis | yes/no |
| Clotting Problems | yes/no | Heart Disease | yes/no | Chronic Infection | yes/no |
| Osteoporosis | yes/no | RA/Lupus | yes/no | High Cholesterol | yes/no |
| Post Menopausal | yes/no | COPD | yes/no | Heart Failure | yes/no |

Please list all other medical problems/illnesses (any reason for which you are seing or have seen a doctor:

______________________________________________________________________________

______________________________________________________________________________

Do you take antibiotics before dental work? yes/no → If yes, what antibiotic? ______________________________

**Past Surgical History:**

Please list any previous surgeries and dates:

Surgery Date

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Medication List:**
Please list all medications you are taking, including nonprescription drugs, vitamins and herbals (use separate sheet if necessary).

Medication name & Dose: How often:

______________________________________________
______________________________________________
______________________________________________
______________________________________________
______________________________________ ____________

**Allergies or Reactions to Medications**

Medication Type of Reaction:

______________________________________________
______________________________________________
______________________________________________
______________________________________________

**Family History**

Has any blood relative ever had the following (please **circle**):

| | | | | | |
|---|---|---|---|---|---|
| Breast cancer | yes/no | Melanoma | yes/no | Stroke | yes/no |
| High blood pressure | yes/no | Heart Disease | yes/no | Diabetes | yes/no |
| Kidney disease | yes/no | Depression/anxiety | yes/no | Anesthesia problems | yes/no |
| Bleeding Problems | yes/no | Clotting problems | yes/no | Skin Cancer | yes/no |

Other (Please List) : ____________________________________________

**Social History:**

Your height: ________________ Your weight: _______________ Race: ______________________

Occupation: ______________________________________________

Married, single, divorced, widowed (Circle one)

How many children & ages: ______________________________________________

Do you consume alcohol? Yes/no If yes, type & amount per week: ______________________

Do you smoke? Yes/no Cigars or Cigarettes (please circle) If yes, amount per day: ______________

Do you chew tobacco? Yes/no

Do you ever smoke marijuana (pot)? Yes/no

Have you ever used “street drugs”? Yes/no Type: ______________________

**I verify that the above information is true and accurate to the best of my knowledge.**

______________________________________________

**Signature of patient (or parent if patient is a minor)** **Date**