LFMG New Patient Intake Form

Name____ Date of birth__________________________

Reason for Visit____ Date______________________

Past Medical History:

Please review the list below and check any problems you have had now or in the past

Abnormal Pap Smear		Eczema		Osteopenia	
Acne		Emphysema		Osteoporosis	
ADD/ADHD		Frequent UTI's		Positive TB Skin Test	
Alcohol Abuse		Frequent Sinus Infections		Prostate Problems	
Anemia		Gallstones		Psoriasis	
Anxiety Disorder		Glaucoma		Reflux (heartburn)	
Asthma		Gout		Rheumatoid Arthritis	
Bipolar Disorder		Heart Attack		Rosacea	
Blood Clot		Heart Condition (specify)		Seasonal Allergies	
Blood Transfusion		Hepatitis (specify A, B, C)		Seizures	
Cancer (What kind)		High Blood Pressure		Sexually Trans. Disease	
Chronic Bronchitis		High Cholesterol		Stomach Ulcers (specify)	
Crohn's Disease or IBS		Kidney Disease			
Colon Polyps		Kidney Infections		Stroke	
Depression		Kidney Stones		Tuberculosis	
Diabetes		Lupus		Thyroid Disease	
Diverticulitis		Melanoma or Skin Cancer		Ulcerative Colitis	
Drug Abuse		Migraines		Warts	
Eating Disorder		Osteoarthritis			

Other medical problems or specialists:

____

____

Hospitalizations: ____

Please check or list all of the **SURGERIES** you have had:

	Type of surgery:	Year
	Appendectomy	
	Arthroscopy (joint)	
	Back or Neck Surgery	
	Cataract Surgery	
	Cesarean Section	
	Gallbladder Removal	
	Heart Surgery (specify)	
	Hemorrhoids	
	Hernia	

	Type of surgery:	Year
	Hysterectomy complete/partial	
	BSO	
	Knee Replacement	
	Hip Replacement	
	Mastectomy or Lumpectomy	
	Polyp Removal (colon)	
	Tonsillectomy/Adenoidectomy	
	Tubal Ligation or Vasectomy	
	Plastic Surgery (specify)	

Other surgeries not on list: ____

____

Current Medications: (please include over the counter medications and food supplements)

Please bring a list of your medications to appointment if >6 medications.

Drug Name:	Dose:	How Often?

Drug Name:	Dose:	How Often?

Are you **ALLERGIC** to any medications? **Yes No**

Drug Name:	Reaction:

Women:

Last menstrual period	/ /
Last pap smear n/a	/ /
Last mammogram n/a	/ /
Last bone density	/ /

Age of first period	
# of days in cycle	
# of days in flow	
Are you menopausal	Y N
Age at onset of menopause	

# of pregnancies	
# of live births	
# of miscarriages	
# of abortions	
# of living children	

Family History:

Mother (M): Alive/deceased, cause of death (if applicable) ___________________________

Father (F): Alive/deceased, cause of death (if applicable) ___________________________

Siblings: ____________# of sisters (S) and ____________ # of brothers (B)

X	Condition:	M	F	S	B
	Heart Disease/attack				
	Stroke				
	Diabetes				
	High Blood Pressure				
	High Cholesterol				
	Thyroid Disease				
	Depression				
	Other Mental Illness				
	Alcoholism				
	Asthma				

X	Condition	M	F	S	B
	Osteoporosis				
	Migraines				
	Breast Cancer				
	Colon Cancer				
	Prostate Cancer				
	Lung Cancer				
	Ovarian Cancer				
	Uterine Cancer				
	Skin Cancer				
	Other Cancer				

Other problems that run your family: (heart disease/attack, colon or breast cancer)

____

Social History:

Marital Status (circle one): Single Engaged Married Separated Divorced Widowed

Occupation:

____

If you have any children, please list their names and year of birth:

____

Pets: ____

Hobbies:____

Religion: ____

Health Habits:

1. Do you **smoke currently**? **Yes No** If so, how much? ______ cig/d # of years smoking ________
   If no, did you **smoke in the past**? **Yes No** How many years? _________ How much? ____________pk/d
   Quit date _______
   Are you **exposed to smoke**? **Yes No**
2. Do you drink **Alcohol?** **Yes No** What kind? Beer Wine Liquor Other:_________
   If so, how many times per week? ______ month? ______ year? ______
   Have you ever had a problem with alcohol in the past? Yes No(legal or social)
3. Have you ever used **street drugs? Yes No**
   Which ones? Marijuana IV drugs amphetamines cocaine heroin downers inhalants other _______
   Are you still using? **Yes No** Which ones? ____
4. Are you **sexually active** (in the last year)? **Yes No**
   If yes circle all that apply**: 1 partner multiple partners**
   Male partner(s) Female partner(s)
   Which birth control do you or your partner use? None condoms the pill vasectomy/tubal other______
5. Do you **exercise**? **Yes No** If so, what type and how often?

____

6. Do you wear a **seatbelt**? **Yes No**
7. Do you have a **living will** (do not resuscitate, medical power of attorney)? **Yes No** Please ask for info
8. Is there concern for your **safety?** (emotional, physical, or sexual abuse)? **Yes No**

Health Care Maintenance:

Last colonoscopy	/ /
Last stool card	/ /
Last flu shot	/ /
Last pneumonia shot	/ /
Last shingles shot	/ /
Last tetanus shot	/ /

Medical Records

If you have medical records you would like to transfer to our office, please fill out the authorization to release medical records form which can be found on our website or available at our office.