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LFMG New Patient Intake Form

1. First Name: _____ MI: _____ Last Name: _____ DOB: _____

Reason for Visit: _____ Former Clinic/Provider: _____ Date: _____

Medical History:

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

- ☐ Abnormal pap smear
- ☐ Acne
- ☐ ADD/ADHD
- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Asthma
- ☐ Bipolar Disorder
- ☐ Blood Clot
- ☐ Blood Transfusion
- ☐ Cancer (Specify Below)
- ☐ Crohn's Disease
- ☐ Colon Polyps
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Drug Abuse
- ☐ Eating Disorder
- ☐ Eczema
- ☐ Emphysema/COPD
- ☐ Frequent UTI's
- ☐ Frequent Sinus Infections
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Condition (Specify Below)
- ☐ Hepatitis (Specify A,B,C Below)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ IBS
- ☐ Kidney Disease
- ☐ Kidney Infections
- ☐ Kidney stones
- ☐ Lupus
- ☐ Melanoma/Skin Cancer (Specify Below)
- ☐ Migraines
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Positive TB Skin Test
- ☐ Prostate Problems
- ☐ Psoriasis
- ☐ Reflux (Heartburn)
- ☐ Rheumatoid Arthritis
- ☐ Rosacea
- ☐ Seasonal Allergies
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Sleep apnea
- ☐ Stomach Ulcers (Specify Below)
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Thyroid Disease
- ☐ Ulcerative Colitis
- ☐ Warts

3. Further specifications of medical problems:

_____

4. Other medical problems or specialists:

_____

5. Please check, provide date and details of all SURGERIES you have had:

Type of Surgery	Check any that apply	Date of Surgery	Specify Surgery Details
Appendectomy			
Arthroscopy (Specify Joint)			
Back Surgery (Specify Location)			
Cataract Surgery			
Gallbladder Removal			
Heart Surgery (Specify)			
Hemorrhoids			
Hernia			
Hip Replacement (Specify Right or Left)			
Hysterectomy (Specify Complete or Partial)			
Knee Replacement (Specify Right or Left)			
Lumpectomy (Specify Right or Left)			
Mastectomy (Specify Right or Left)			
Neck Surgery			
Ovaries/Fallopian Tubes Removed			
Plastic Surgery (Specify Type)			
Polyp Removal (Colon)			
Tonsillectomy/Adenoidectomy			
Tubal Ligation/Vasectomy			

Please list any other surgeries you have had here (date and type)

_____

6. Please provide dates of your last Colon Cancer Screenings:

Colon Cancer Screen Type	Date:
Colonoscopy	
Cologuard	
Stool Card	

7. Hospitalizations:

	Reason:	Date
1		
2		
3		

8. Current Medications: (Include over the counter medications and food supplements. Please bring medications in original bottle to every appointment.)

	Drug Name:	Dose:	How Often:
1			
2			
3			
4			
5			
6			

9. Pharmacy: Location:

10. Please list any medications you are ALLERGIC to:

	Drug Name:	Reaction:
1		
2		
3		

11. Please list your last VACCINES (Please do not skip this section):

Vaccine:	Date:
Flu Shot	
Pneumonia Shot	
Shingles Shot	
Tetanus Shot	
COVID Shot	
RSV Shot	

12. For Women Only:

	Answer:
Last Menstrual Period (Date):	
Last Pap Smear (Date/NA):	
Last Mammogram (Date/NA):	
Last DEXA (Date/NA):	
Age of first period:	
# of days in cycle:	
# of days in flow:	
Are you Menopausal? (Yes/No):	
Age at onset of Menopause (Date/NA):	
# of pregnancies:	
# of live births:	
# of miscarriages:	
# of abortions:	
# of living children:	

Family History:

13. Parents:

	Living Status	Cause of death (if applicable)
Mother		
Father		

14. Siblings:

How many sisters do you have? _____

How many brothers do you have? _____

15. Please check all health problems that run in your family:

Condition	Mother	Father	Sister	Brother
Heart Disease				
Heart Attack				
Diabetes				
High Blood Pressure				
High Cholesterol				
Thyroid Disease				
Depression				
Other Mental Illness				
Alcoholism/Drug Addiction				
Osteoporosis				
Migraines				
Breast Cancer				
Colon Cancer				
Prostate Cancer				
Lung Cancer				
Ovarian Cancer				
Uterine Cancer				
Skin Cancer				
Other Cancer (Specify)				
Other (Specify)				

If other, please specify

_____

16. Children:

	Name	Date of Birth
1		
2		
3		

Social History:

17. Marital Status:

○ Single ○ Engaged ○ Married
○ Separated ○ Divorced ○ Widowed

18. Who lives with you:

_____

19. Occupation:

_____

○ Full-time ○ Part-time ○ Retired ○ Per diem ○ Unemployed

20. Pets:

_____

21. Education:

_____

22. Hobbies:

_____

23. Religion:

_____

24. Support System (check all that apply):

☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Husband ☐ Wife ☐ Son ☐ Daughter ☐ Other (specify below)

If other, please specify:

_____

25. Do you live in an assisted living or nursing home?

○ Assisted Living ○ Nursing Home ○ No

26. Tobacco:

Do you use tobacco?
○ Yes ○ Former ○ Never

If current user, what type(s) do you use? (Check all that apply)
☐ Cigarettes ☐ Cigars ☐ Vape ☐ Pipe ☐ Chewing Tobacco
☐ Dipping Tobacco

How many packs/times per day? _____

How many years? _____

If former, when did you quit? _____

27. Alcohol:

Do you drink alcohol?
○ Yes ○ Former
○ Never

If current drinker, what do you drink? (Check all that apply)
☐ Beer ☐ Wine ☐ Liquor ☐ Other

If other, please specify: _____

How many times per month? _____

Have you ever had a problem with alcohol in the past?
○ Yes ○ No

28. Recreational Drugs:

Have you use recreational drugs?
○ Yes ○ Former ○ Never

What substances have you used? (Check all that apply)
☐ Cannabis ☐ Cocaine ☐ Prescription Stimulants
☐ Methamphetamine ☐ Inhalants ☐ Sedatives or Sleeping Pills
☐ Hallucinogens ☐ Street or Prescription Opioids ☐ Other

If other, please specify: _____

In the past year, what recreational drugs have you used? _____

In the past year, how often have you used? _____

29. Sexual Health:

Are you sexually active (in the last year)?
○ Yes ○ No

If yes, please check all that apply:
☐ One Partner ☐ Multiple Partners ☐ Male Partner(s)
☐ Female Partner(s)

What birth control do you or your partner use (check all that apply)?
☐ None ☐ Condoms ☐ The Pill ☐ Vasectomy/Tubal ☐ Other

If other, please specify: _____

30. Diet:

☐ Regular ☐ Diabetic ☐ Gluten Free
☐ Low Fat ☐ Vegan ☐ Vegetarian
☐ Kosher ☐ DASH ☐ Other

If other, please specify: _____

31. Exercise:

Do you exercise?
○ Yes ○ No

If so, what kind of exercise? _____

How many times per week? _____

32. Is there concern for your safety?

- Yes
- No

33. Do you wear a seatbelt?

- Yes
- No

34. Do you have a living will?

- Yes
- No