TRI-COUNTY FAMILYMEDICINE
NEW PATIENT INTAKE FORM

Name:	**Date of Birth:**	**Date Completed:**

MEDICATIONS

Please list any medications that you are currently taking and the dosage of each. *Place a check mark next to any that need refills.*

Please attach list if needed

Please check here if you do not have any medication allergies ◯
Please check here if you are not on any medications ◯

ALLERGIES (Including medication, food and environmental):
◯ **No Known Allergies** ◯ Aspirin ◯ Barbiturates ◯ Iodine ◯ Latex/rubber
◯ Local Anesthetics ◯ Penicillin ◯ Metals ◯ Sedatives ◯ Sulfa
◯ Other

RECENT HISTORY

Name of Previous Physician:	Phone	
Have you been seen in the ER in the last 10 days?	Yes	No
Have you been an inpatient at a hospital, rehab, detox or nursing facility in the last 21 days?	Yes	No
Do you have any URGENT medical needs that require you to be seen immediately?	Yes	No

Please explain briefly:
Who is your health care proxy? (please provide us with a copy of the documents)

Do you have an advance directive document? (Please provide us with copy)	Yes	No
Have you seen a specialist recently? (i.e. Neurologist, Orthopedist, Cardiologist, Behavioral Health, etc.)	Yes	No
Would you like to see a counselor?	Yes	No
For pediatric patients: is the patient in need of immunizations or a time-sensitive physical?	Yes	No
Do you need an antibiotic prior to dental treatment? If yes, please explain:	Yes	No

Please check any of the following that you need assistance with:

◯ Reading/Writing ◯ Housing ◯ Health Insurance ◯ Language/Interpreter ◯ Transportation

HEALTH ISSUES

◯ AIDS/HIV	◯ Excessive Bleeding	◯ Obesity	◯ Pregnancy, Due Date
◯ Anxiety	◯ Fainting	◯ Radiation Treatment	◯ Rheumatic Fever
◯ Ability to sleep	◯ Growths	◯ Liver Disease	◯ Sexually Transmitted Infection
◯ Arthritis	◯ Hay Fever	◯ Pacemaker	◯ Sinus Problems
◯ Asthma/Emphysema	◯ Heart Disease/Heart Attack	◯ Ulcers	◯ Stroke
◯ Artificial Joints	◯ Heart Murmur	◯ Glaucoma	◯ Thyroid Disease
◯ Blood Disease	◯ Hepatitis	◯ Throat	◯ Tuberculosis
◯ Cancer	◯ High Blood Pressure	◯ Rheumatism	◯ Tumors
◯ Depression	◯ Jaundice	◯ Lungs	◯ Vision Problems
◯ Diabetes	◯ Kidney Disease	◯ Stomach Problems	◯ Diabetic Neuropathy
◯ Dizziness	◯ Respiratory Problems	◯ Head Injuries	◯ Other
◯ Epilepsy	◯ Alcohol/Drug Dependency	◯ Mental Disorders	

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WOMEN ONLY

Are you pregnant or do you think you might be pregnant?		Yes	No
Are you currently breastfeeding?		Yes	No
When was your last Pap smear?	Abnormal Pap Smear?	Yes	No
When was your last mammogram?	Abnormal Mammogram?	Yes	No
At what age did you get your first menstrual cycle?		Yes	No
Are you post-menopausal? At what age?			

Please complete and sign on the last page.

TRI-COUNTY FAMILY
NEW PATIENT HEALTH HISTORY

Name:	**Date of Birth:**	**Date Completed:**

Date of last physical exam:	Date of last dental exam:
Provider:	Dentist:
Provider Address:	Dentist Address:
Provider Phone:	Dentist Phone:
Do you take, or have ever taken, bisphosphonate drugs (e.g. Fosamax, Actonel, Boniva)?	◯ Yes ◯ No
Have you had a DEXA scan?	◯ Yes ◯ No If yes, when was it?
Have you ever been hospitalized? ◯	◯ Yes ◯ No If yes, what for?
When was your last colonoscopy?	
When was your last tetanus shot?	

SOCIAL HISTORY

Hazardous material exposure?	◯ Yes ◯ No	Specify	
Do you use tobacco products (include vaping)?	◯ Yes ◯ No	Type:	How much/How long?

How often do you drink alcohol?	# of drinks per day	Type:
Have you ever used street drugs?	◯ Yes ◯ No	Type:
Do you drink caffeinated beverages?	◯ Yes ◯ No	Type:
Do you drink sweetened beverages?	◯ Yes ◯ No	Type
Are you on any selective diet?	◯ Yes ◯ No	Type:
Do you exercise?	◯ Yes ◯ No	What kind/how often?

What is the highest level of education you have attained?

What sexual orientation do you identify yourself as?	◯ Straight	◯ Lesbian or Gay	◯ Bisexual
	◯ Something else	◯ Don't know	◯ Choose not to Disclose
What gender do you identify yourself as?	◯ Male	◯ Female	◯ Other
	◯ Transgender Male (Female to Male)	◯ Transgender Female (Male to Female)	◯ Choose Not to Disclose

What is your current housing situation?	◯ I have housing	◯ I do not have housing
Are you worried about losing your housing?	◯ Yes	◯ No
What is your current work situation?	◯ Unemployed and seeking work	◯ Part-time or temporary work
	◯ Full-time work	◯ Unemployed, but not seeking work

In the past year, have you or any of your family members you live with been unable to get any of the following when it was really needed?			
◯ Food	◯ Clothing	◯ Utilities	◯ Child Care
◯ Medicine or any health care	◯ Phone	◯ Other	◯ No problems meeting my needs

Has lack of transportation kept your from medical appointments, meetings, work or from getting things needed for daily living?	◯ Yes	◯ No
How often do you see or talk to people that you care about and feel close to?	◯ Less than once a week	◯ 1 or 2 times a week
	◯ 3 to 5 times a week	◯ More than 5 times a week
How stressed are you?	◯ Not at all	◯ A little bit
◯ Somewhat	◯ Quite a bit	◯ Very much
In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center or juvenile correctional facility?	◯ Yes	◯ No
Are you a refugee?	◯ Yes	◯ No
What country are you from?	◯ United States	◯ Other
Do you feel physically and emotionally safe where are currently live?	◯ Yes	◯ No

In the past year, have you been afraid of your partner or ex-partner?	◯ Yes	◯ No	◯ Unsure

Signature:_____

Date:_____

Reviewed by provider (initials): _____