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MEDICAL INTAKE FORM

Patient Name_____ Age_____D.O.B._____

Parent Name - If minor_____

What brings you into the office today?_____

_____

What Expectations do you have for this visit?_____

_____

What are your major health concerns in order of importance?_____

_____

_____

_____

_____

_____

Date of last Physical Exam:_____ Date of last Dental Exam:_____

List any medications, over the counter drugs, vitamins, or other supplements you are taking. Feel free to use an additional page._____

_____

_____

List any allergies to drugs, foods or chemicals_____

_____

List any medical problems that you have had in the past. Have you ever been hospitalized or had surgery? If so, when and why?_____

_____

_____

FAMILY MEDICAL HISTORY:

Please note the diseases that each of the following members of your family has or had. If they are deceased, please note the age at which they died and the cause of their death:

Mother:_____

Father:_____

Paternal Grandmother:_____

Paternal Grandfather:_____

Maternal Grandmother:_____

Maternal Grandfather:_____

Siblings:_____

_____

DIET:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Number of alcoholic beverage consumed per week?_____ Do you smoke or use illicit drugs? Y N

SLEEP: Hours of sleep per night?_____ Do you wake rested? Y N

EXERCISE: Hours spent in physical activity per week?_____ Type of exercise:_____

_____

HOBBIES?_____

TOXICITY EXPOSURE: Number of crowns and fillings?_____ How many mercury (silver)?_____

Have you ever lived near or worked in agriculture or major industry? Y N

Any known exposures?_____