

MEDICAL INTAKE SHEET

Date: / /

Patient Name:

D.O.B.:

New Patient or Established Patient:

Physician Seeing Today:

Referring Doctor:

Reason for Visit:

Vital Signs- Weight: Height:

Pharmacy Information:

Allergies:

Medications:

Chronic Medical Conditions (high BP, high cholest, cancer, diabetes, asthma, depression, migraines, etc):

Surgeries/Year:

Family Chronic Medical Conditions:

Mom:

Dad:

Brother:

Sister:

Social History-

Occupation:

Married, Single, Divorced, Widowed

Daughters:

Sons:

Smoker:

Drinker:

Salt intake:

Caffeine:

Kids History:

Residence:

Pets?:

Smokers?: