PATIENT INTAKE FORM

Name: _____ Date: _____ DOB: _____

Pharmacy: _____ Primary Care Physician: _____

PLEASE ADD ALL INFORMATION

Current allergies include: _____

Current medications include: _____

_____

Medical history includes: _____

_____

_____

Surgical history includes: _____

_____

_____

Your Pregnancy history includes: (Please use the back of this form for any additional information)

Number	Date	Delivery Type	Infant Weight	Comments

- Name of Husband/Significant Other: _____
- 1st day of your last period: _____
- Current method of Birth Control: _____
- Your family history includes _____
- Please list any Sexually Transmitted Diseases you have had: _____
- Smoking History (Please Circle One): Current ☐ Former ☐ Never ☐
- Alcohol Use (Please Check One) Daily ☐ Every Other Day ☐ Socially ☐ Never ☐
- Drug Use _____
- **Please Circle if you have had any of the following in the last week:**

General	**Prenatal**	**GYN**	**Cardiovascular**	**Respiratory**
Fever	Nausea	Vaginal Discharge	Chest Pain	Cough
Fatigue	Vomiting	Incontinence	Heart Palpitations	Wheezing
Weight Loss	Headache	Painful Urination	Swelling	
Headache	Swelling of the Legs	Blood in Urine		
Depression	Abdominal cramps	Urinary Frequency		
Anxiety	Vaginal Discharge	Absence of Menstruation		
Gastrointestinal	**Endocrine**	Abnormal Vaginal Bleeding	**Breast**	**Musculoskeltal**
Diarrhea	Cold Intolerance	Pelvic Pain	Breast Lump	Muscle Weakness
Constipation	Heat Intolerance	Genital Sores	Breast Pain	Restless Legs
Change in Bowels Habits		Decreased Libido	Nipple Discharge	
Stomach Pain				
Blood in Stool				
Heartburn				
Dermatology	**Neurology**	**Psychiatric**	**Ear/Nose/Throat**	
Rash	Seizures	Suicidal Ideation	Nose Bleeds	
Itching				
Dryness				
Suspicious Lesions				