Patient Intake & Health History Form

Your/Patient's Basic Information

Full Name:	Birthdate:
Sex: ☐ Male ☐ Female	Marital status: ☐ Single ☐ Married ☐ Other
Reason for visit:	
Ethnicity: ☐ Hispanic or Latino/a ☐ Not Hispanic or Latino/a ☐ Choose not to specify	
Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African-American ☐ Native Hawaiian/Other ☐ White ☐ Choose not to specify	
Preferred Language: ☐ English ☐ Other: ___________________________	

How to Contact You

Email Address:		
Street Address:		
City:	State:	Zip Code:
Cell Phone #:	Alternate Phone #:	

Please indicate which of the following methods of contact we are authorized to use if we need to report lab test results or remind you of your appointment:

☐ Email ☐ Mail ☐ Cell phone ☐ Alternate phone

Other Contact Information

Emergency Contact Name:		
Relationship to You:	Phone Number:	
How did you find us? / Who referred you? :		
Preferred Pharmacy:	Phone Number:	
Pharmacy's Street Address:		
City:	State:	Zip Code:

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Insurance Information (leave blank if self-paying)	
Insurance Company:	
Primary/Policy holder:	
Primary's birthdate:	Relationship to You:
Primary's Insurance ID #:	Group #:

Current Medications/Medication Allergies	
Any medication you're currently taking? Include vitamins, supplements and over the counter. Please list **drug name and dosage** below:	Any allergies to medication? Please list the **name of the medication and the type of reaction** (rash, breathing issues, etc.) below:
1.	1.
2.	2.
3.	3.

Your Medical History

Do you have now/Have you ever had the following diseases or conditions? Check if yes:

	Diabetes		Kidney Stones		Yeast Infections
	Asthma		Cancer (type: _______________)		Ulcers
	Tuberculosis (TB)		Convulsions, Epilepsy or Seizures		Heart Disease
	Thyroid		Fainting		Blood Clots
	Depression		Bleeding Disorder		Chest Pain
	High Blood Pressure		Stroke		Other (please list):
	Heart Murmur		Seasonal Allergies/Hay Fever		__________________

List any surgical procedures you've had in the last 6 mos.:

Meaningful Use

How often do you smoke? : ☐ Never ☐ Used to ☐ Sometimes ☐ Every day

	Please check if applicable in the last 12 months:		If female, also answer the following:
	Vaccinated against influenza		Screened for breast cancer (mammogram)
	Vaccinated against pneumonia		Screened for urinary incontinence
	Had a colorectal screening		Screened for osteoporosis (last 12 mos.)

Almost Done!

Please sign to confirm the above information is correct to the best of your knowledge:	
X ____	Date:

I authorize the release of any medical information necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to be made to me or on my behalf to Steven Swengel, MD & Associates for any services furnished me by said physician. If outside laboratory services are necessary, I authorize payment to be made on my behalf to said laboratory:	
X ____	Date: