Southwest Family Physicians
YOUR FAMILY IS OUR FAMILY

NEW PATIENT INTAKE FORM

Name:_____ Date:____/____/_____
Gender: **M** **F** Birthdate:___/___/_____ SSN____-____-_____ Preferred Language: _____
Home Phone: (____) _____-_____ Best Time:_____
Mobile Phone: (____) _____-_____ Best Time:_____
Is it okay to leave a detailed message concerning your appointment at these numbers? **Yes** **No**
Street Address: _____
City:_____ State:_____ Zip Code: _____
Occupation:_____ Employer:_____
Email Address:_____
Emergency Contact:_____ Phone:(____) _____-_____
Please list any health concerns that you have at this time:_____
_____
Please list any medications or supplements that you have been prescribed and/or are currently taking:

Medication or Supplement	Dosage	Frequency	Duration	Reason

Do you have any allergies to medications?_____
Do you have any other significant allergies?_____
Do you have any other medical conditions?_____
_____
Date of last Tetanus Shot:_____/_____/_____ Are you up to date on your Immunizations? **Y N**
Please list any prior surgeries, injuries or traumatic events:_____
_____
Please circle all which with you identify: Single Partner Married Separated Divorced Lesbian Gay Straight Bisexual Transgender

Health Habits
Do you eat a special diet? **Y N** Describe_____
Do you exercise regularly? **Y N** Frequency and Duration_____
Do you use tobacco products? **Y N** Have you ever? **Y N** End Date: _____/_____/_____
Do you use intoxicants? **Y N** Please Explain _____
Do you drink soda? **Y N** Frequency? _____ Amount: _____
Do you drink alcohol? **Y N** Frequency and amount: _____ Type: _____

Family History

Do you have any biological relative with any of the following?
Please indicate relationship to you for all "YES" answers.

Condition	YES	NO	Relation
Breast Cancer			
Colon Cancer			
Other Cancer			
Diabetes			
Addiction			
Mental Illness			

Condition	YES	NO	Relation
Heart Attack			
Stroke			
High Blood Pressure			
Thyroid Disease			
Blood Disorder			
Other			

Symptom Review

Do not mark if symptoms aren't present. However if you do, rate symptoms: **1** = Mild, **2** = Moderate, **3** = Severe.

Head and Face
Headaches 1 2 3
Allergies 1 2 3
Memory Loss 1 2 3
Other: 1 2 3

Eyes
Poor Vision 1 2 3
Eye Pain 1 2 3
Inflammation 1 2 3
Other: 1 2 3

Ears
Poor Hearing 1 2 3
Earaches 1 2 3
Discharge 1 2 3
Ringing 1 2 3
Other: 1 2 3

Nose
Frequent Colds 1 2 3
Sinus Trouble 1 2 3
Bleeding 1 2 3
Difficulty Breathing 1 2 3
Other: 1 2 3

Mouth
Gum Problems 1 2 3
Teeth Problems 1 2 3
Jaw Problems 1 2 3
Unusual Tastes 1 2 3
Other: 1 2 3

Throat
Sore Throat 1 2 3
Hoarseness 1 2 3
Difficulty Swallowing 1 2 3
Other: 1 2 3

Body Pain
Arthritis/Rheumatoid 1 2 3
Muscle Pain 1 2 3
Difficulty Laying Flat 1 2 3
Tightness in Chest 1 2 3
Other: 1 2 3

Circulation
Palpitation 1 2 3
High Blood Pressure 1 2 3
Low Blood Pressure 1 2 3
Bruise Easily 1 2 3
Bleed Easily 1 2 3
Slow Wound Healing 1 2 3
Cold Limbs 1 2 3
Other: 1 2 3

Gastrointestinal
Excess Thirst 1 2 3
Excess Appetite 1 2 3
Weight (Gain) (Loss) 1 2 3
Digestive Pain 1 2 3
Nausea 1 2 3
Vomiting 1 2 3
Diarrhea 1 2 3
Constipation 1 2 3
Blood in Stool 1 2 3
Colon Problems 1 2 3
Hemorrhoids 1 2 3
Other: 1 2 3

Urination
Frequent 1 2 3
Difficulty 1 2 3
Nighttime 1 2 3
Bleeding 1 2 3
Painful 1 2 3
Describe: 1 2 3

Skin
Rashes 1 2 3
Dryness 1 2 3
Moles or Lumps 1 2 3
Excess Sweat 1 2 3
Night Sweat 1 2 3
Rarely Sweat 1 2 3
Other: 1 2 3

Neurological
Dizziness 1 2 3
Nervousness 1 2 3
Tremors 1 2 3
Seizures 1 2 3
Numbness/tingling 1 2 3
Loss of Balance 1 2 3
Nerve Pain 1 2 3
Other: 1 2 3

Energy
Low (fatigue) 1 2 3
High 1 2 3

Women's Health
Pelvic Pain 1 2 3
Menopausal sx 1 2 3
Vaginal Discharge 1 2 3
Difficulty Conceiving 1 2 3
Sexual Difficulties 1 2 3
Other: 1 2 3

Number of Pregnancies:
Number of Living Children:

Menstrual Cycle
Irregular 1 2 3
Excess Blood 1 2 3
Lack of Blood 1 2 3
Dark Colored Blood 1 2 3
Light Colored Blood 1 2 3
Bleeding Midcycle 1 2 3
Clotting 1 2 3
Water Retention 1 2 3
Breast Tenderness 1 2 3
Emotional Changes 1 2 3
Painful (cramping) 1 2 3

Sleep
Insomnia 1 2 3
Drowsiness 1 2 3
Dream Disturbance 1 2 3
Describe: 1 2 3

Mental Health
Depression 1 2 3
Anxiety 1 2 3
Irritability 1 2 3
Other: 1 2 3

Men's Health
Prostate Problems 1 2 3
Genital Pain 1 2 3
Genital Swelling 1 2 3
Sexual Difficulties 1 2 3
Other: 1 2 3