Wall Family Medical
Howell Family Medical

Patient Intake Form

Date: __ __ \ __ __ \ __ __ __ __

Name: _____

Address: _____

_____

City: _____

State: __ __ Zip Code: __ __ __ __ __

Primary Care Provider: _____

Date of Birth: __ __ \ __ __ \ __ __ __ __

Preferred Language: _____

Home Phone: __ __ __ - __ __ __ - __ __ __ __

Cell Phone: __ __ __ - __ __ __ - __ __ __ __

Work Phone: __ __ __ - __ __ __ - __ __ __ __

Email: _____

Are you hearing or visually impaired? (Circle)

Hearing **Visual**

Do you have a living will? ☐Yes ☐No

Please **check off** your preferred contact method:

☐Home ☐Cell ☐Work ☐Email

Local Pharmacy: _____

Mail Order Pharmacy: _____

Please list all current medications (including supplements/over the counter), dose, and frequency:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____

Please list all medical problems you have been diagnosed with (e.g. diabetes, depression, hypertension):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Have you been hospitalized in the last year? ☐Yes ☐No **Explain:** _____

_____

Please list any other doctors you see:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Please provide last GYN visit date:_____ **GYN Name:**_____

Please turn over

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List ANY allergies below (drug or otherwise):

_____

Occupation: _____ Marital Status (Circle):

Where do you work? _____ **Single Married Divorced Widowed**

Who do you live with? _____ Exercise: ☐Yes ☐No # days/week: _____

Alcohol Use: ☐None ☐Yes # Drinks/Week: _____ Tobacco: ☐Never ☐Current ☐Quit When? _____

If you currently smoke, are you interested in quitting? ☐Yes, I am ☐No, I'm not interested

Health Maintenance			
	Date	**Performing Physician and/or facility:**	**Check if none:**
Colonoscopy			☐
PSA			☐
Mammogram			☐
Pap Smear			☐
Immunizations			
Influenza			☐
Pneumonia			☐
Shingles			☐
Tetanus			☐

Family History		
Does your family have a history of any of the following?		**Family Member(s):**
Breast Cancer	☐Yes ☐No	
Colon cancer or polyps	☐Yes ☐No	
Gynecological cancer	☐Yes ☐No	
Prostate cancer	☐Yes ☐No	
Skin cancer	☐Yes ☐No	

You are done!