ADULT NEW PATIENT INTAKE FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____
DOB: _____ Age: _____ Male or Female: _____ Social Security #: ____-___-_____
Home Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____)_____-_____ Cell Phone: (____)_____-_____ Preferred contact : □Home □Cell
Email: _____
Employer: _____ Occupation: _____Work Phone: (____)_____-_____
Emergency Contact Name: _____ Relationship: _____ Phone: (____)_____-_____
Preferred Pharmacy: _____ Pharmacy phone #: (____)_____-_____
Preferred Pharmacy Address: _____

Collection of the following information is encouraged by federal health agencies. This information is used to monitor and improve the quality of care provided to all patients.
Ethnicity: Race:

□ Decline Response □ Hispanic or Latino □ Not Hispanic or Latino
□ American-Indian or Alaska Native □ Asian □ White/Caucasian
□ Black or African American □ Native Hawaiian or Pacific Islander □ Other
□ Preferred Language: _____ □ Decline Response

Insurance Information

Health Insurance Company: _____ ID # _____ Group # _____
Secondary Insurance: _____ ID # _____ Group # _____
Policy Holder Name & DOB (if different from patient): _____
Other If Applicable (circle type): Work Comp, Auto Accident. Please fill out all applicable information below:
Insurance Company: _____ Phone Number: _____ Address: _____
Date of accident: _____ Claim Number: _____ Adjuster's Name: _____
Adjuster's Phone Number: _____

Patient Financial Obligation Agreement

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits be paid directly to Agape Family Medical Center for services rendered. I authorize representatives of Agape Family Medical Center to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Notice of Privacy Practices

I acknowledge that I was provided with a copy of the Agape Family Medical Center Notice of Privacy Practices (NOPP).
□ Received □ N/A (only if you received the notice from Agape Family Medical Center previously)

Patient or Legal Guardian Name (Print): _____
Patient or Legal Guardian Signature: _____ Date:_____

Reason for today's visit: _____

General Medical Questionnaire

Have you EVER had any of the following?

Asthma/Breathing Problems..... □ Y □ N
Arthritis..... □ Y □ N
Bleeding/Clotting Disorder..... □ Y □ N
Blood Pressure Disorder..... □ Y □ N
Blood Transfusion ..... □ Y □ N
Bowel/Stomach Problems..... □ Y □ N
Cancer..... □ Y □ N
Cholesterol Disorder ..... □ Y □ N
Diabetes..... □ Y □ N
Eye Disorder (i.e. Glaucoma, cataract)..... □ Y □ N
If Relevant: Gynecological Issues……□ Y □ N

Heart Disease/Disorder .....□ Y □ N
Lung Disorder .....□ Y □ N
Liver Disease .....□ Y □ N
Neurological Disorder/Chronic Headaches ….□ Y□ N
Psychiatric Disorder/Illness.....□ Y□ N
Pulmonary Embolism/DVT.....□ Y □ N
Stroke.....□ Y □ N
Seizure or Epilepsy .....□ Y □ N
Thyroid Disorder .....□ Y □ N
Urinary/Kidney Disorder.....□ Y □ N

Please list any other medical illnesses or problems and provide details for any of the above conditions:

_____
_____
_____

Please list all past surgeries and hospitalizations and the approximate date.

Procedure/surgery	Date

Please indicate any major conditions/illnesses that your immediate family members have had:
Relative Condition and description Living?

Relative	Condition and description	Living?
Mother		□ Y □ N
Father		□ Y □ N
Sibling		□ Y □ N
Other		□ Y □ N

Tobacco:

Do you currently smoke? □ Y □ N

If no, previously? □ Y □ N

Years smoked _____ Packs/day _____

Alcohol:

Consume alcohol? □ Y □ N

If yes, drinks/week: _____

Do you have any allergies to medications or other substances (pets, food, etc.)? □Y □N

If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis):

Allergy	Reaction

Please list ALL your current medications, including over the counter medications, supplements, and herbs:

Medication Name	Dose	Medication Name	Dose

Recent Tests: Give month/year of last exam in right column.

Test	Month/Year	Test	Month/Year
Bone Density		Hep B	
Colonoscopy		Hep C	
Diabetic Foot Exam		HIV	
Eye Exam		Covid 19	
Mammogram		Flu shot	
Pap Smear		Immunizations	
Physical		If 60 and over: Shingles shot	
PSA		If 65 and over: Pneumonia shot	

Women Only:

Age at meses onset: _____
Date of last period: _____
Name of GYN: _____
Number of Pregnancies: _____
Number of Children: _____
Pregnancy Complications:
_____

Painful period ☐ Yes ☐No
Vaginal Discharge ☐ Yes ☐No
Breast Pain ☐ Yes ☐No
Breast Lump ☐ Yes ☐No
Post-menopausal bleeding ☐ Yes ☐No

Men Only:

Weak Urine Stream: ☐ Yes ☐No
Discharge from Penis: ☐ Yes ☐No
Painful / Swollen testis: ☐ Yes ☐No
Prostate Trouble: ☐ Yes ☐No

Review of Systems

Please check any current symptoms you are having.

CONSTITUTIONAL:

☐ Weight Loss/Gain
☐ Fatigue
☐ Fever
☐ Chills
☐Insomnia
☐ Change in appetite
☐ Hoarseness
☐Night sweats

RESPIRATORY:

☐ Cough
☐ Coughing blood
☐ Wheezing
☐ Snoring
☐ Shortness of breath

EYES:

☐ Eye Pain
☐ Vision Changes
☐ Eyesight Problems
☐ Itchy Eyes
☐ Dry Eyes

EAR/NOSE/THROAT:

☐ Earache
☐ Loss of hearing
☐ Nose bleeds
☐ Sinus problems
☐ Sore throat

CARDIOVASCULAR:

☐ Chest pain with activities
☐ Palpitations
☐ Fast heart rate
☐ Slow heart rate
☐ Leg swelling
☐ Leg pain, discomfort, fatigue during walking
☐ Leg pain, discomfort, fatigue while laying in bed
☐ Shortness of breath with activities

GASTROINTESTINAL:

☐ Abdominal pain
☐ Constipation
☐ Diarrhea
☐ Heartburn
☐ Nausea
☐ Vomiting
☐ Blood in stool

BLADDER:

☐ Incontinence
☐ Discolored urine
☐ Painful urination
☐ frequent urination
☐ Nocturia
☐ Difficulty starting a urine stream or completely emptying bladder

HEMATOLOGY/LYMPH:

☐ Easy bruising
☐ Gums bleed easily
☐ Enlarged glands

SKIN:

- □ Acne
- □ Itching
- □ Change in a mole
- □ Skin lesions
- □ Skin wound
- □ Skin Cancer

NEUROLOGICAL:

- □ Confused
- □ Convulsions
- □ Dizziness
- □ Limb weakness
- □ Loss of memory
- □ Headaches
- □ Difficulty walking

PSYCHIATRIC:

- □ Anxiety
- □ Depression
- □ Change in personality
- □ Suicidal
- □ Disturbed sleep
- □ Emotional problems

ENDOCRINE:

- □ Weak muscles
- □ Feeling weak
- □ Deepening of voice
- □ Hair loss
- □ Hot flashes