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:_____

Agape
Family Medical Center

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

Agape
Family Medical Center

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	

Agape
Family Medical Center

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

Agape
Family Medical Center

SKIN:	NEUROLOGICAL:	PSYCHIATRIC:	ENDOCRINE:
□ Acne	□ Confused	□ Anxiety	□ Weak muscles
□ Itching	□ Convulsions	□ Depression	□ Feeling weak
□ Change in a mole	□ Dizziness	□ Change in personality	□ Deepening of voice
□ Skin lesions	□ Limb weakness	□ Suicidal	
□ Skin wound	□ Loss of memory	□ Disturbed sleep	□ Hair loss
□ Skin Cancer	□ Headaches	□ Emotional problems	□ Hot flashes
	□ Difficulty walking		