LFMG New Patient Intake Form

Name:_____Date of birth:_____ Former clinic/Provider:
Reason for Visit:_____Date:_____ _____

Medical History: Please review the list below and check any problems you have had now or in the past.

Abnormal pap smear		Emphysema/COPD		Osteopenia	
Acne		Frequent UTI's		Osteoporosis	
ADD/ADHD		Frequent Sinus Infections		Positive TB Skin Test	
Alcohol Abuse		Gallstones		Prostate Problems	
Anemia		Glaucoma		Psoriasis	
Anxiety Disorder		Gout		Reflux (heartburn)	
Asthma		Heart Attack		Rheumatoid Arthritis	
Bipolar Disorder		Heart Condition (specify)		Rosacea	
Blood Clot		Hepatitis (specify A,B,C)		Seasonal Allergies	
Blood Transfusion		High Blood Pressure		Seizures	
Cancer (what kind)		High Cholesterol		Sexually Trans. Disease	
Crohn's Disease		IBS		Sleep Apnea	
Colon Polyps		Kidney Disease		Stomach Ulcers(specify)	
Depression		Kidney Infections		stroke	
Diabetes		Kidney Stones		Tuberculosis	
Diverticulitis		Lupus		Thyroid Disease	
Drug Abuse		Melanoma or Skin Cancer (Type)		Ulcerative Colitis	
Eating Disosrder		Migraines		Warts	
Eczema		Osteoarthritis			

Other medical problems or specialists:_____

Hospitalizations reason/date: _____

Please check, circle, or list all **SURGERIES** you have had:

Type of Surgery	Date	Type of Surgery	Date	Type of Surgery	Date
Appendectomy		Hysterectomy Complete / Partial(cervix left)		Polyp Removal (colon)	
Arthroscopy (joint)		Ovaries/Fallopian Tubes Removed		Neck Surgery	
Back Surgery(location)		Knee Replacement R__ L__		Plastic Surgery (specify)	
Cataract Surgery		Hip Replacement R__ L__		Hemorrhoids	
Gallbladder Removal		Mastectomy R_ L__		Tubal Ligation/Vasectomy	
Heart Surgery (specify)		Lumpectomy R__ L__			

Hernia		Tonsillectomy /Adenoidectomy			

Current Medications: (Please include over the counter medications and food supplements)
Please bring medications in original bottle to every appointment.

Drug Name:	Dose:	How Often?		Drug Name:	Dose:	How Often?

Pharmacy:_____Location:_____

Are you **ALLERGIC** to any medications: **Yes** **No**

Drug Name:	Reaction:

Women: Date

Last Menstrual Period		Age of first period		# of pregnancies	
Last Pap Smear n/a		# of days in cycle		# of live births	
Last Mammogram n/a		# of days in flow		# of miscarriages	
Last Bone Density		Are you Menopausal?	Y N	# of abortions	
		Age at onset of Menopause		# of living children	

Family History:

Mother(M) :Alive/deceased, cause of death (if applicable) _____
Father (F) :Alive/deceased, cause of death (if applicable)_____
Siblings:_____How many sisters? (S)_____How many brothers?(B)_____

Condition	M	F	S	B		M	F	S	B
Heart Disease					Colon Cancer				
Heart Attack					Prostate Cancer				
Diabetes					Lung Cancer				
High Blood Pressure					Ovarian Cancer				
High Cholesterol					Uterine Cancer				
Thyroid Disease					Skin Cancer				
Depression					Other Cancer (Specify)				
Other Mental Illness					Other…..				
Alcoholism/Drug Addiction									
Osteoporosis									
Migraines									
Breast Cancer									

Other problems that run your family: (Heart disease/attack, colon or breast cancer)

_____

Social History:

Marital Status (circle one): Single Engaged Married Separated Divorced Widowed

Lives with:_____

Occupation:_____Full-time Part-time Retired Per diem Unemployed

Children name and date of birth if applicable_____

Pets:_____
Education: _____
Hobbies:_____
Religion:_____
Support System: Mother Father Sister Brother Husband Wife Son Daughter Other_____
Do you live in an assisted living or nursing home?_____

Do you smoke? Y N Tobacco cigars vape pipe chewing tobacco dipping tobacco
How many packs per day? _____
Did you smoke in the past? Y N How many years?_____ Quit date:_____

Do you drink alcohol Yes No What Kind? Beer Wine Liquor Other: _____
How many times per month?_____
Have you ever had a problem with alcohol in the past? Yes No

Have you ever used street drugs? Yes No
Which ones: Marijuana IV drugs amphetamines cocaine heroin downers inhalants other_____
Are you still using: Yes No Which ones?_____

Are you sexually active (in the last year)? Yes No

If yes circle all that apply: 1 partner multiple partners Male partner(s) Female partner(s)

Which birth control do you or your partner use? None condoms the pill vasectomy/tubal other_____

Diet: Regular diabetic gluten free low fat vegan vegetarian kosher dash other_____

Exercise: Yes No What kind?_____ How many times per week?_____

Is there concern for your safety? (emotional, physical, or sexual abuse)? Yes No
Do you wear a seatbelt? Yes No
Do you have a living will? Yes No

When was your last: **(Please do not skip this section)**

Procedure/vaccine	Date:
Colonoscopy	
Last stool card	
Last flu shot	
Last pneumonia shot	
Last shingles shot	
Last tetanus shot	
Last COVID shot	

Procedure/vaccine	Date:
Mammogram	
DEXA	

If you have medical records you would like to transfer to our office, please fill out the authorization to release medical records form, it can be found on our website or available at our office.