Intake Form

Name: ____ **Date of birth:** ___________________

Address: ____

Preferred Pharmacy: ______________________ **Address:** ____

Primary Care Provider: ____

Referring Provider: ____

Medications/supplements. List Name(s) and Dosage below. Attach additional sheet if necessary.

____

____

____

Allergies. List Name(s) and Reactions below. Attach additional sheet if necessary.

____

____

____

Social History: (select one) ____ Married ____ Partner ____ Single ____ Divorced

Are you safe? ____ Yes ____ No

Who do you live with? ____

What do you do for exercise? ____

What do you do for work? ____

What tobacco/nicotine products do you use? ____

Did you use tobacco/nicotine products in the past? ____ Yes; When? ______________________ ____ No

Do you drink alcohol? ____ Yes; How often? ____ ____ No

What other drugs do you use? ____

Mental health history:

Intake Form

Do you/did you experience anxiety?
____ Yes; What treatments?
____
____ No
Do you/did you experience depression?
____ Yes; What treatments?
____
____ No
Do you/did you experience mood issues?
____ Yes; What treatments?
____
____ No
Were you hospitalized for anxiety, depression and/or mood issues? ____ Yes ____ No

Family history:
Mom Alive? ____ Yes ____ No; Age at death: _____
Mom's Medical history:
____

Dad Alive? ____ Yes ____ No; Age at death: _____
Dad's Medical history:
____

Mother's Mother Alive? ____ Yes ____ No; Age at death: _____
Mother's Mother's Medical history:
____

Mother's Father Alive? ____ Yes ____ No; Age at death: _____
Mother's Father's Medical history:
____

Father's Mother Alive? ____ Yes ____ No; Age at death: _____
Father's Mother's Medical history:
____

Father's Father Alive?____ Yes ____ No; Age at death: _____
Father's Father's Medical history:
____

Sister(s) Alive? ____ Yes ____ No; Age at death: _____
Sister(s) Medical history:
____

Brother(s) Alive? ____ Yes ____ No; Age at death: _____
Brother(s) Medical history:
____

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Intake Form

Daughter(s) Alive? ____ Yes ____ No; Age at death: _____
Daughter(s) Medical history:

____

Son(s) Alive? ____ Yes ____ No; Age at death: _____
Son(s) Medical history?

____

Surgical history: attach additional sheet if necessary

____
____
____
____
____
____

Medical problems: attach additional sheet if necessary

____
____
____
____
____
____
____
____

Gynecological history:
First period occurred at ________ years old
Date of last period: __________
Cycles are: ____ regular ____ irregular
Cycle length is: ____ 28-30 days ____ >30 days ____ <28 days
Cycle flow is: ____ light ____ heavy
Pain with: ____ periods ____ sex ____ urination ____ BMs ____ other:
____
History of: ____ endometriosis ____ cysts ____ fibroids ____ pelvic inflammatory disease
____ sexually transmitted infections
Pregnancy, number of: pregnancies ____ living children ____ full term births ____ premature births ____
stillbirths ____ c-section(s) ____ spontaneous miscarriage(s) ____ therapeutic abortion(s) ____