Medical: Full Intake Form

Medical Intake Form

1. Please enter your information.

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Gender:
○ Female ○ Male ○ Transgender ○ Non-binary
○ Other

Marital Status:
○ Single ○ Married ○ Domestic Partner
○ Separated ○ Divorced ○ Widowed

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone
○ Email

2. Please attach a copy of your photo ID

3. Preferred Language:

○ English ○ Hindi ○ Spanish
○ Gujarati ○ Punjabi ○ Other

If other, please specify:

_____

4. Race (Please check all that apply):

☐ White ☐ Black ☐ Asian
☐ American Indian/Native Alaskan ☐ Native Hawaiian/Pacific Islander ☐ Other

If other, please specify:

_____

5. Ethnicity:

☐ Hispanic/Latino(a) ☐ Not Hispanic/Latino(a)

6. How did you learn about this office? _____ Who referred you? _____

7. Emergency Contact: Relationship:

Address: City, State & Zip:

Phone: Alt. Phone:

8. Previous Primary Doctor: Phone:

Other Health Provider: Phone:

Preferred Pharmacy (name and address): Phone:

9. Is it ok to leave a detailed message on your home or mobile phone number listed?

○ Yes ○ No

10. At Onestop Medical Clinic, we communicate regularly with patients via phone, email, and/or text messages regarding things like appointment confirmations and health maintenance. Please provide consent to communications you would like to receive.

Communication Method	I consent to:	I do not consent to:
Text Messages	Yes	No
Phone Calls	Yes	No
Emails	Yes	No

11. Would you like us to be able to discuss your medical condition(s) (including diagnosis, results, treatments, and care received) with a member(s) of your family?

○ Yes ○ No

12. Please list individuals (and relationship) with whom you allow us to share your health information:

	First and Last Name	Relationship
1)		
2)		
3)		

13. Do you have Medical Insurance?

○ Yes ○ No

14. Primary Insurance

Primary Insurance Company | Member ID / Policy # | Group Number

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name | Insured Phone # | Insured Date of Birth | Insured Gender ○ Female ○ Male

Insured Street Address | Insured City | Insured State | Zip Code

Do you have secondary insurance?
○ Yes ○ No

15. Please upload a copy of the front and back of your primary insurance card

16. Secondary Insurance

Secondary Insurance Company | Member ID / Policy # | Group Number

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name | Insured Phone # | Insured Date of Birth | Insured Gender ○ Female ○ Male

Insured Street Address | Insured City | Insured State | Zip Code

17. Please upload a copy of the front and back of your secondary insurance card

18. I authorize the release of any medical information necessary to process my claim and payment of benefits.

Authorization to bill insurance

Signature | Date

What brings you to the clinic? (Please list your reason for visit)

19. Problem 1:

Please describe the reason for visit or issue you're experiencing:

How long have you had this problem?

How severe is this problem?
○ Mild ○ Moderate ○ Severe

Have you tried anything to treat this problem?

20. Problem 2:

Please describe the issue you're experiencing:

How long have you had this problem?

How severe is this problem?
○ Mild ○ Moderate ○ Severe

Have you tried anything to treat this problem?

21. Problem 3:

Please describe the issue you're experiencing:

How long have you had this problem?

How severe is this problem?
○ Mild ○ Moderate ○ Severe

Have you tried anything to treat this problem?

Review of Systems

Do you have any problems with the following? Please check the correct box:

22. Constitutional

- ☐ Fatigue
- ☐ Fevers/Chills
- ☐ Unexplained weight loss
- ☐ Unexplained weight gain
- ☐ Night Sweats
- ☐ None

23. Neurological:

- ☐ Confusion
- ☐ Dizzy/Lightheaded
- ☐ Headaches
- ☐ Memory problems
- ☐ Numbness
- ☐ Tingling
- ☐ None

24. Eyes:

- ☐ Blurry/Double Vision
- ☐ Burning
- ☐ Redness
- ☐ Loss of Vision
- ☐ None

25. Ear/Nose/Throat:

- ☐ Congestion
- ☐ Ear Pain
- ☐ Facial pain/numbness
- ☐ Hoarseness
- ☐ Nose bleeds
- ☐ Sinus pain
- ☐ Ringing in the Ears
- ☐ None

26. Respiratory:

- ☐ Blood in Sputum
- ☐ Persistent Coughing
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Wheezing
- ☐ None

27. Cardiovascular:

- ☐ Angina/Chest Pain
- ☐ Ankle Swelling
- ☐ Exercise Intolerance
- ☐ Heart Palpitation
- ☐ Leg Pain with Walking
- ☐ Wake Short of Breath
- ☐ None

28. Gastrointestinal:

- ☐ Abdominal Pain
- ☐ Blood in Stool
- ☐ Black Stool
- ☐ Bloating
- ☐ Constipation
- ☐ Diarrhea
- ☐ Food Intolerance/Sensitivity
- ☐ Heartburn
- ☐ Nausea/Vomiting
- ☐ Stool Incontinence
- ☐ None

29. Genitourinary:

- ☐ Blood in urine
- ☐ Nighttime urination
- ☐ Heavy/Painful Menses
- ☐ Infertility
- ☐ Impotence
- ☐ Prostate Problems
- ☐ Urine Incontinence
- ☐ Burning with urination
- ☐ Urinary Frequency
- ☐ None

30. Allergy/Immunology:

- ☐ Frequent Infections
- ☐ Past Anaphylaxis
- ☐ Seasonal Allergies
- ☐ Swollen Glands
- ☐ None

31. Hematology:

- ☐ Bleed/Bruise Easily
- ☐ Blood Clots
- ☐ Past Blood Transfusion
- ☐ None

32. Musculoskeletal:

- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Pain
- ☐ Muscle Weakness
- ☐ None

33. Skin/Breast:

- ☐ Breast Lump
- ☐ Skin Rash
- ☐ Nipple Discharge
- ☐ Dry Skin
- ☐ None

34. Psychiatric:

- ☐ Anxiety
- ☐ Depression
- ☐ Disordered Eating
- ☐ Poor Sleep
- ☐ Suicidal Thoughts
- ☐ None

Medical History

35. When was your last:

	Date
Annual Physical	
Eye Exam	
Dental Exam	

36. Do you have now (or have you ever had):

Anxiety	Yes	No	Past
Asthma/Emphysema	Yes	No	Past
Arthritis	Yes	No	Past
Blood Clots	Yes	No	Past
Bowel disease	Yes	No	Past
Chronic Pain	Yes	No	Past
Depression	Yes	No	Past
Diabetes Type I	Yes	No	Past
Diabetes Type II	Yes	No	Past
Eye Disease	Yes	No	Past
Heart Attack/Angina	Yes	No	Past
Heart Disease	Yes	No	Past
High Cholesterol	Yes	No	Past
High Blood Pressure	Yes	No	Past
Immune Disorder	Yes	No	Past
Kidney Disease	Yes	No	Past
Kidney Stones	Yes	No	Past
Liver Disease	Yes	No	Past
Migraines	Yes	No	Past
Neurologic Disorder	Yes	No	Past
Osteoporosis	Yes	No	Past
Recurrent Infections	Yes	No	Past
Seizures/Epilepsy	Yes	No	Past
Stroke/TIA	Yes	No	Past
Thyroid Problems	Yes	No	Past
Vascular Disease	Yes	No	Past
Cancer	Yes	No	Past

37. If YES to any of the above, please explain:

Surgical History

38. Have you ever had surgery?

○ Yes ○ No

39. Please list your previous surgeries:

	Operation	Month/Year
1		
2		
3		

40. List any medications, vitamins, or supplements (if none, type none to continue):

	Medication Name	Dosage	Frequency	Reason for taking
1				
2				
3				

41. Recent antibiotic use in the past 6 months?

○ Yes ○ No

42. Allergies?

○ Yes ○ No Known Allergy

43. If yes, please list including reaction:

	Allergy	Reaction
1		
2		
3		

44. Shellfish/Iodine/IV contrast?

○ Yes ○ No

If yes, reaction:

_____

45. Latex?

○ Yes ○ No

46. FEMALES:

Date of Last menstrual period:

Age at first period:

Are you on contraceptives?
○ Yes ○ No

If yes, please name:

Menopause?

Hysterectomy?

Ovaries removed?

Hormone replacement?
○ Yes ○ No

List:

# of Pregnancies:

# of C-Sections:

# of Vaginal:

# of Abortions:

# of Miscarriages:

Pregnancy Complications:
○ Yes ○ No

If yes, please explain:

Date of last pap smear:

Abnormal pap smear(s)?
○ Yes ○ No

Date of last mammogram:

Abnormal?
○ Yes ○ No

47. MALES:

Vasectomy?
○ Yes ○ No

Impotence?
○ Yes ○ No

Erectile Dysfunction?
○ Yes ○ No

Weak urine stream?
○ Yes ○ No

Last PSA result:

Prostate Exam:

Health

48. Do you:

Smoke Tobacco?
○ Yes ○ No ○ Past

If past, date quit:

Packs/Day:

Years:

Drink alcohol?
○ Yes ○ No ○ Past

If past, date quit:

_____

Have you ever felt a need to cut down on your drinking?

○ Yes ○ No

49. Drink caffeine?

○ Yes ○ No ○ Past

50. Type(s) and cup/s a day:

☐ Coffee: _____

☐ Tea: _____

☐ Soda/Pop: _____

☐ Other: _____

51. Do you have dietary restrictions?

○ Yes ○ No

If yes, please explain:

_____

52. Use recreational drugs?

○ Yes ○ No ○ Past

53. Please list:

_____

54. Are you Physically Active > 30 min/day:

○ Yes ○ No

55. If yes, how many times per week:

○ 5 or more times per week ○ 3-4 times per week ○ 1-2 times per week

○ Less than 1 time per week

56. Types of Exercise:

_____

57. Sexually Active?

○ Yes ○ No

58. If yes, new partner in the last year?

○ Yes ○ No

59. With:

○ Men ○ Women ○ Both

Family History

60. Do you have a family (parent, sibling or child) history of:

	Yes	No	If yes, who?
Alzheimer's disease	Yes	No	
Heart Disease	Yes	No	
Stroke	Yes	No	
High Blood Pressure	Yes	No	
Diabetes	Yes	No	
Cancer	Yes	No	
Mental Illness	Yes	No	
Other, please specify	Yes	No	

If with Cancer/Mental Illness, please specify type:

_____

Health Maintenance

61. Please indicate results (if known):

Colonoscopy:
○ Polyps ○ Diverticulosis ○ Routine Screening

Other:
_____

Bone Density:
_____

Chest X-ray:
_____

Cholesterol:
_____

EKG:
_____

Thyroid/TSH:
_____

62. Check off any received Immunizations and enter date (if known):

☐ Flu Vaccine
_____

☐ Hepatitis A
_____

☐ Hepatitis B
_____

☐ Tetanus (Td) or (TDaP)
_____

☐ Pneumococcal
_____

☐ Meningococcal
_____

☐ Varicella
_____

☐ MMR
_____

☐ COVID-19
_____

☐ Shingles
_____

☐ None
_____

☐ Other:
_____

If other, please specify:

_____

Social History

63. Have you been abused?

- ○ Yes
- ○ No

64. If yes:

- ○ Verbal
- ○ Physical
- ○ Sexual

65. Do you see/talk to someone you feel close to more than once a week?

- ○ Yes
- ○ No

66. Have you travelled outside of the country in the last 2 years?

- ○ Yes
- ○ No

If yes, where?

_____

Education/Employment

67. Education Level:

- ○ Less than high school
- ○ High School Diploma
- ○ Some college
- ○ College Degree
- ○ Professional or Graduate Degree

68. Employment:

- ○ Full time
- ○ Part time
- ○ Retired
- ○ Not seeking employment
- ○ Seeking employment
- ○ Student

69. Occupation:

_____

70. Exposure to chemicals/hazardous materials?

- ○ Yes
- ○ No

If yes, please explain:

_____

Safety

71.

Do you:	Yes	No
Wear a seatbelt?	Yes	No
Do you wear sunscreen?	Yes	No
Have a place to live?	Yes	No
Exposed to 2nd hand smoke?	Yes	No
Wear a helmet for sports?	Yes	No
Have a gun in the house?	Yes	No
If yes, is the gun locked up?	Yes	No

Medical Forms

Do you have the following:

72. Advanced Directive?

○ Yes ○ No

73. If yes, please attach copy:

74. Durable Power of Attorney?

○ Yes ○ No

75. If yes, please attach a copy:

76. Living Will?

○ Yes ○ No

77. _____

I certify that I am the patient or an authorized representative and the above information is truthful and correct to the best of my knowledge

_____ _____

Signature Date