The Village Doc
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PATIENT INTAKE FORM

Patient Name: ______________________________ **DOB:** ______________

List in Order of Importance what your problems are:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Last time you had blood work done and with what physician: ______________________________

Family History

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living:	____	____	____	____	____	____
Age when died:	____	____	____	____	____	____
Reason for death:	____	____	____	____	____	____
Cancer type:	____	____	____	____	____	____
High Blood Pressure:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/Stroke:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/Allergies:	Y N	Y N	Y N	Y N	Y N	Y N
Mental Illness:	Y N	Y N	Y N	Y N	Y N	Y N
TB:	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus:	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis:	Y N	Y N	Y N	Y N	Y N	Y N

List All Surgeries & Hospitalizations, including date occurred:

1. ______________________________ 4. ______________________________
2. ______________________________ 5. ______________________________
3. ______________________________ 6. ______________________________

Please Note When & Why You Have Had Each of the Following:

X-Rays: ______________________________ **MRI/Cat Scan:** ______________________________

Ultrasounds: ______________________________ **Accidents:** ______________________________

TB Test: ______________________________ **HepC, EBV, etc:** ______________________________

HIV: ______________________________ **Last Dental Visit:** ______________________________

Last Eye Exam: ______________________________ **Allergies:** ______________________________