HEALTH INTAKE FORM: NEW PATIENT

Patient Name: _____ **Date:**_____

Reason/Main Concern For Your Visit Today: _____

Specialist Physicians (other than the Primary Physician):

1. _____ 2. _____ 3. _____

Current Medications:

Medication Name:	Dose/Amount:	Frequency/times per day:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies:

Medication Name:	Reaction:
_____	_____
_____	_____

Pharmacy: Name: _____

Address: _____

History of:

Surgeries (Type & Date)	Hospitalizations Overnight (Reason & Date)
_____	_____
_____	_____
_____	_____

Family History:

Any family member:

born with a congenital heart defect?	Yes	No
with a history of an irregular or abnormal heart rhythm?	Yes	No
heart disease/heart attack/surgery before the age of 50?	Yes	No
cardiac or unexplained sudden death before the age of 50?	Yes	No

Are there any other concerns or questions for today's visit?