CLASSEN FAMILY MEDICINE CLINIC

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NEW PATIENT INTAKE FORM

Please list any medications or supplements that you have been prescribed and/or are currently taking:

Medication or Supplement	Dosage/ Strength	Frequency
		◯ Daily ◯ 2xdaily ◯ 3xdaily ◯ 4xdaily ◯ As needed
		◯ Daily ◯ 2xdaily ◯ 3xdaily ◯ 4xdaily ◯ As needed
		◯ Daily ◯ 2xdaily ◯ 3xdaily ◯ 4xdaily ◯ As needed
		◯ Daily ◯ 2xdaily ◯ 3xdaily ◯ 4xdaily ◯ As needed
		◯ Daily ◯ 2xdaily ◯ 3xdaily ◯ 4xdaily ◯ As needed
		◯ Daily ◯ 2xdaily ◯ 3xdaily ◯ 4xdaily ◯ As needed
		◯ Daily ◯ 2xdaily ◯ 3xdaily ◯ 4xdaily ◯ As needed
		◯ Daily ◯ 2xdaily ◯ 3xdaily ◯ 4xdaily ◯ As needed

Should further space be needed please add another sheet. If in office ask for another page to continue on.

Do you have any allergies to medications?____
Do you have any other significant allergies?____
Do you have any other medical conditions?____
____
Date of last Tetanus Shot, if known:_____/_____/________ Are you up to date on your Immunizations? **Y** ◯ **N** ◯
Please list any prior surgeries, injuries or traumatic events:___________________________________
____

Health Habits

Do you eat a special diet? **Y** ◯ **N** ◯ Describe____

Do you exercise regularly? **Y** ◯ **N** ◯ Frequency and Duration____________________________________

Do you use tobacco products? **Y** ◯ **N** ◯ How much per day?_________ Type_______________
Have you ever? **Y** ◯ **N** ◯ How many years?_____ End Date: _____/_____/________

Do you drink soda? **Y** ◯ **N** ◯ How much per day? _______

Do you drink alcohol? **Y** ◯ **N** ◯ Frequency and amount: _____________ Type: ________________

Family History

Do you have any biological relative with any of the following?
Please indicate relationship to you for all "YES" answers.

Condition	YES	NO	Relation
Breast Cancer	☐	☐	
Colon Cancer	☐	☐	
Other Cancer	☐	☐	
Diabetes	☐	☐	
Addiction	☐	☐	
Mental Illness	☐	☐	

Condition	YES	NO	Relation
Heart Attack	☐	☐	
Stroke	☐	☐	
High Blood Pressure	☐	☐	
Thyroid Disease	☐	☐	
Blood Disorder	☐	☐	
Other	☐	☐	

Symptom Review

Do not mark if symptoms aren't present. However if you do, rate symptoms: **1** = Mild, **2** = Moderate, **3** = Severe.

Head and Face	1	2	3
Headaches	○	○	○
Allergies	○	○	○
Memory Loss	○	○	○
Other:	○	○	○
Eyes			
Poor Vision	○	○	○
Eye Pain	○	○	○
Inflammation	○	○	○
Other:	○	○	○
Ears			
Poor Hearing	○	○	○
Earaches	○	○	○
Discharge	○	○	○
Ringing	○	○	○
Other:	○	○	○
Nose			
Frequent Colds	○	○	○
Sinus Trouble	○	○	○
Bleeding	○	○	○
Difficulty Breathing	○	○	○
Other:	○	○	○
Mouth			
Gum Problems	○	○	○
Teeth Problems	○	○	○
Jaw Problems	○	○	○
Unusual Tastes	○	○	○
Other:	○	○	○
Throat			
Sore Throat	○	○	○
Hoarseness	○	○	○
Difficulty Swallowing	○	○	○
Other:	○	○	○
Body Pain			
Arthritis/Rheumatoid	○	○	○
Muscle Pain	○	○	○
Difficulty Laying Flat	○	○	○
Tightness in Chest	○	○	○
Other:	○	○	○

Circulation	1	2	3
Palpitation	○	○	○
High Blood Pressure	○	○	○
Low Blood Pressure	○	○	○
Bruise Easily	○	○	○
Bleed Easily	○	○	○
Slow Wound Healing	○	○	○
Cold Limbs	○	○	○
Other:	○	○	○
Gastrointestinal			
Excess Thirst	○	○	○
Excess Appetite	○	○	○
Weight (Gain) (Loss)	○	○	○
Digestive Pain	○	○	○
Nausea	○	○	○
Vomiting	○	○	○
Diarrhea	○	○	○
Constipation	○	○	○
Blood in Stool	○	○	○
Colon Problems	○	○	○
Hemorrhoids	○	○	○
Other:	○	○	○
Urination			
Frequent	○	○	○
Difficulty	○	○	○
Nighttime	○	○	○
Bleeding	○	○	○
Painful	○	○	○
Describe:	○	○	○
Skin			
Rashes	○	○	○
Dryness	○	○	○
Moles or Lumps	○	○	○
Excess Sweat	○	○	○
Night Sweat	○	○	○
Rarely Sweat	○	○	○
Other:	○	○	○

Neurological	1	2	3
Dizziness	○	○	○
Nervousness	○	○	○
Tremors	○	○	○
Seizures	○	○	○
Numbness/tingling	○	○	○
Loss of Balance	○	○	○
Nerve Pain	○	○	○
Other:	○	○	○
Energy			
Low (fatigue)	○	○	○
High	○	○	○
Women's Health			
Pelvic Pain	○	○	○
Menopausal sx	○	○	○
Vaginal Discharge	○	○	○
Difficulty Conceiving	○	○	○
Sexual Difficulties	○	○	○
Other:	○	○	○

Number of Pregnancies: _____
Number of Living Children: ____

Menstrual Cycle			
Irregular	○	○	○
Excess Blood	○	○	○
Lack of Blood	○	○	○
Dark Colored Blood	○	○	○
Light Colored Blood	○	○	○
Bleeding Midcycle	○	○	○
Clotting	○	○	○
Water Retention	○	○	○
Breast Tenderness	○	○	○
Emotional Changes	○	○	○
Painful (cramping)	○	○	○

Sleep	1	2	3
Insomnia	○	○	○
Drowsiness	○	○	○
Dream Disturbance	○	○	○
Describe:	○	○	○
Mental Health			
Depression	○	○	○
Anxiety	○	○	○
Irritability	○	○	○
Other:	○	○	○
Men's Health			
Prostate Problems	○	○	○
Genital Pain	○	○	○
Genital Swelling	○	○	○
Sexual Difficulties	○	○	○
Other:	○	○	○