Southeast Medical Clinic
Owned and Operated by Catherine Peimann MD, LLC
641 W. Willoughby Ave, Suite 201
Juneau, AK 99801
Phone: (907) 586-8100
Fax: (907) 586-8102

Catherine Peimann, MD
Dana Richards, MS, PA-C
Anne Standerwick, MD
Sarah Niecko, DHSc, MS, PA-C
Kaitlyn Bausler, FNP
Kelly Erickson, PA-C

PATIENT INFORMATION

Legal Name:	Preferred Name:
Sex Assigned at Birth:	
Gender Identity: ☐Male ☐Female ☐ Transgender Male/FTM ☐Transgender Female/MTF ☐Gender Non-binary ☐ Not listed_____	
Pronouns (circle all that apply): she/her/hers he/him/his they/them/theirs Not listed_____	
Date of Birth:	
Social Security:	
Mailing Address:	
City, State, Zip:	
Home Phone:	Cell Phone:
Employer:	Work Phone:
Which phone do you prefer calls to?	
E-mail Address:	
Preferred Pharmacy:	
Race (circle/list all that apply): ☐ American Indian ☐ AK Native ☐ African American ☐ Asian ☐ Hispanic ☐ Hawaiian ☐ Other Pacific Islander ☐ White ☐ Other	
Ethnicity: ☐ Hispanic/Latin ☐ Not Hispanic/Latin	
Preferred Language:	

EMERGENCY CONTACT

Name:	
Relationship:	
Mailing Address:	
City, State, Zip:	
Phone:	Alternate Phone:

INSURANCE INFORMATION

☐ **SELF PAY**

Primary Ins:	Secondary Ins:
Policy ID#	Policy ID#
Group#	Group#
Policyholder Info: ☐ Self ☐ Other *If Other, enter info below*	Policyholder Info: ☐ Self ☐ Other *If Other, enter info below*
Name on Plan:	Name:
Date of Birth:	Date of Birth:
Phone:	Phone:
Address:	Address:
Relationship to Policyholder:	Relationship to Policyholder:
Please give additional insurance info to receptionist.	

Southeast Medical Clinic

Owned and Operated by Catherine Peimann MD, LLC

Medical Intake Form

Name:	**Date:**
Date of Birth/Age:	**Who referred you?**

Reason for Today's Visit:

Past Medical History/Illnesses:	**Past Surgical History (Operations/date)**

Medications (name, dose, frequency)	6.
1. e.g.- aspirin, 325 mg, once per day	7.
2.	8.
3.	9.
4.	10.
5.	11.

**Please include aspirin, herbs, vitamins and over the counter medications*

Drug allergies (e.g. penicillin)	**Reaction (e.g. hives)**

Family History: Please mark all that apply and WHO has had it (i.e. Diabetes: mother)

Diabetes:	Arthritis:	Anemia:
High Blood Pressure:	Allergy/Asthma:	Bleeding disorder:
Heart Disease:	Kidney Disease:	Seizures:
Stroke:	Tuberculosis:	Ulcers:
High Cholesterol:	Mental Illness/Suicide:	Thyroid Disease:
Obesity:	Glaucoma:	
Cancer (type):	Not listed:	

Health Habits: Please circle/note the most accurate answer(s)

Tobacco Use:					
Smoking status/history	I smoke everyday	I smoke some days	I am a former smoker	I have never smoked	
How many years have you smoked?	<5	5-10	11-15	16-20	>20
How many packs per day do/have	¼	½	1	1.5	2 or more

you smoked?					
Smokeless tobacco status/history	Current Years:	Former Years:	Never		
E-cigarette/Vape History	Current Years:	Former Years:	Never		
If you use any of the above, are you interested in quitting?	No/Yes				

Alcohol Use:					
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times/month	2-3 times/week	4 or more times/week
How many drinks do you have on a typical day when you are drinking alcohol?	1-2	3-4	5-6	7-9	10 or more
How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	2-3 times/week	4 or more times/week
Recreational Drug Use:					
Do you use recreational Drugs? No/Yes: Type_____					

Sexual History (Please circle all that apply or leave blank if you prefer not to disclose)

How do you describe your sexual orientation?	Straight	Lesbian/Gay	Bisexual	Asexual	Queer	Not listed:
Do you use protection?	Yes	No	If yes, what type?			

Over the past 2 weeks, how often have you been bothered by the following problems? (Please circle)

Little interest or pleasure in doing things?	Not at all (0)	Several days (1)	More than half of the days (2)	Nearly all of the days (3)
Feeling down, depressed or hopeless?	Not at all (0)	Several days (1)	More than half of the days (2)	Nearly all of the days (3)

Prevention (Please answer all questions that apply to you):

Last Colonoscopy:	Last Mammogram/Normal?
Last Bone Density:	Last PAP/Normal?
Last Prostate Exam:	Last STD Screening/Normal?

Pregnancy (Please circle/note the appropriate answer or leave blank if not applicable):

Have you ever been pregnant?	No	Yes	
Number of:	Pregnancies:	Miscarriages:	Abortions:

If there is anything else you think is important for your provider to know, please share it in the provided space: