Broad Top Area Medical Center

New Patient Intake Form

We'd like to welcome you as a new patient. Please take the time to fill out this form as accurately as possible so we can most appropriately address your health needs. The confidentiality of your health information is protected in accordance with federal protections for the privacy of health information under the Health Insurance Portability and Accountability Act (HIPAA).

Primary Care

Name _____
D.O.B. _____

Prior Primary Care Provider

_____

Other specialist seen within past 2 years _____

_____

_____

Allergies or reactions to medications?

_____

_____

Have you been or are you treated for any ongoing **health problems**? (For example, high blood pressure, diabetes, thyroid problems, cancer, breathing problems, arthritis, depressions, or other conditions)

_____

_____

_____

_____

_____

Have you been **hospitalized for any illness or Surgery**? If so, when was it?

_____

_____

Problems or concerns now with any of the Following?

Heart_____

Lungs _____

Head/ears/nose/mouth _____

Neck or throat_____

Abdomen/stomach/intestines_____

_____

Muscles or joints_____

Nervous System_____

Mood or emotions_____

Skin_____

Other_____

Family History Medical Problems Alive?

Mother_____

Father_____

Brothers/Sisters_____

_____

_____

_____

Children_____

_____

Health Habits

Do you or did you ever smoke?
_____

Drink alcohol?
_____

Routine exercise?
_____

Caffeine?
_____

Have you ever had a problem with alcohol abuse Or drug abuse(prescription drugs?)

_____

Have you ever been physically or sexually abused?
_____

Are there any specific concerns you would like to address at this first appointment?

_____

_____

_____

Past Immunization History- give approximate date or supply immunization record

Tetanus/dt/Tdap? _____

Pneumonia vaccine?_____

Flu shot?_____

Hepatitis B?_____

Gardasil (HPV)?_____

Zostavax (Shingles)?_____

Other vaccines for school, travel, etc?

_____

_____

Health Maintenance- give approximate dates

Colonoscopy_____

Pap smear/Gyn Exam_____

Mammogram_____

Rectal exam_____

Eye Exam_____

Dental Exam_____

List current medications, with dose and frequency, and any other vitamins and/or supplements

Medicine Dose Reason for med/Doctor

_____

_____

_____

_____

_____

_____

_____

_____

_____

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