Community Hospital-Fairfax Family Medicine Clinics

Patient Intake Form

Thank you for choosing Community Hospital-Fairfax Family Medicine Clinics. We are delighted to provide your care. If you are a patient of the Rock Port, Tarkio or Fairfax Clinics, please complete this form. Thank you!

Patient Demographic Information

First Name

Middle Name

Last Name

Address

City

State, Zip

Primary Phone

Secondary Phone

Email

Gender

☐Male

☐Female

Date of Birth

Employment Status

☐Employed

☐Retired

☐Unemployed

Employer

Employer Address

Employer Phone

Emergency Contact

Emergency Contact Phone

Advance Healthcare Directive

☐Yes ☐No

Name of Person Completing Form if NOT the Patient:_____

Relationship:_____

Allergies

Name of Allergy	Reaction	Severity	Onset Date
	☐Rash ☐Itching ☐Hives ☐Shortness of Breath ☐Abdominal Pain ☐Diarrhea ☐Cough Other_____	☐Mild ☐ Mild to Moderate ☐Moderate ☐Moderate to Severe ☐Severe ☐Anaphylaxis	
	☐Rash ☐Itching ☐Hives ☐Shortness of Breath ☐Abdominal Pain ☐Diarrhea ☐Cough Other_____	☐Mild ☐ Mild to Moderate ☐Moderate ☐Moderate to Severe ☐Severe ☐ Anaphylaxis	
	☐Rash ☐Itching ☐Hives ☐Shortness of Breath ☐Abdominal Pain ☐Diarrhea ☐Cough Other_____	☐Mild ☐ Mild to Moderate ☐Moderate ☐Moderate to Severe ☐Severe ☐Anaphylaxis	
	☐Rash ☐Itching ☐Hives ☐Shortness of Breath ☐Abdominal Pain ☐Diarrhea ☐Cough Other_____	☐Mild ☐ Mild to Moderate ☐Moderate ☐Moderate to Severe ☐Severe ☐Anaphylaxis	

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Name of Allergy	Reaction	Severity	Onset Date
	☐Rash ☐Itching ☐Hives ☐Shortness of Breath ☐Abdominal Pain ☐Diarrhea ☐Cough Other_____	☐Mild ☐ Mild to Moderate ☐Moderate ☐Moderate to Severe ☐Severe ☐Anaphylaxis	

Preventative Care

If 18 and under, are you up to date with your immunizations? ☐ Yes ☐No

Immunization/Screening	Date Last Received	Immunization/Screening	Date Last Received
☐Influenza		☐Colon Cancer Screening	
☐Pertussis		☐Glaucoma Screening	
☐Pneumonia Prevnar-13		☐Diabetes Test	
☐Pneumovax 23		☐Hepatitis B	
☐Pneumonia (Unsure what type)		☐Hepatitis C	
☐Lung Cancer Screening (If History of Smoking)		☐HIV or Sexually Transmitted Disease	
☐Prostate Screening (Males)		☐Aortic Aneurysm Screening	
☐Mammogram (Female)		☐Bone Density	
☐ Pap Smear/Pelvic Exam (Female)		☐Shingles Vaccine	
☐Tetanus/Diphtheria		☐HPV	

Functional/Cognitive Status

Check any that apply to you.

☐Deafness of Right Ear ☐Deafness of Left Ear ☐Hearing Loss of Right Ear ☐Hearing Loss of Left Ear
☐Blind Left Eye ☐Blind Right Eye ☐Other_____

Surgical and Procedural History

Please include DATE IF KNOWN.

☐None ☐Bariatric surgery (include type) _____ ☐Cataracts _____
☐Hysterectomy _____ ☐LASIK _____ ☐Endoscopy _____
☐Tonsillectomy _____ ☐Colonoscopy _____ ☐Thyroidectomy _____
☐Hernia _____ ☐Adenoidectomy _____ ☐Spinal Surgery _____
☐Coronary Bypass _____ ☐Tubal Ligation _____ ☐Cardiac Stents _____
☐ Bladder surgery _____ ☐Pacemaker _____ ☐Prostate surgery/resection _____
☐Heart Valve_____ ☐C-section _____ ☐Gall Bladder _____
☐Orthopedic/joints (Type and Side) _____ ☐Appendectomy _____
☐Bowel/Stomach Resection _____ ☐Vasectomy _____ ☐Other_____

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Medications

(If you have a current list of medications, please copy, attach to intake form and proceed to the next section.)

Name of Medication	Type	Dose (ml or mg)	Route	Frequency	Pharmacy Location	Indication (For What)
	☐Prescription ☐ Over the Counter		☐Oral ☐Injected ☐Other___________			
	☐Prescription ☐ Over the Counter		☐Oral ☐Injected ☐Other___________			
	☐Prescription ☐ Over the Counter		☐Oral ☐Injected ☐Other___________			
	☐Prescription ☐ Over the Counter		☐Oral ☐Injected ☐Other___________			
	☐Prescription ☐ Over the Counter		☐Oral ☐Injected ☐Other___________			
	☐Prescription ☐ Over the Counter		☐Oral ☐Injected ☐Other___________			
	☐Prescription ☐ Over the Counter		☐Oral ☐Injected ☐Other___________			

Primary Care Provider

Who is your primary care provider? _________________________Clinic Location_________________________________

Specialists

Name of Doctor, Specialty	Location	Last Appointment

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Family History

	Check if "Yes"	First Degree Relative (Mother, Father, Siblings, Children), Condition Specifics		Check if "Yes"	First Degree Relative (Mother, Father, Siblings, Children), Condition Specifics
Unknown	☐		Genetic Disorder	☐	
Asthma	☐		Heart Problems	☐	
Allergies	☐		High Blood Pressure	☐	
Arthritis	☐		High Cholesterol	☐	
Blood Diseases	☐		Obesity	☐	
Cancer (Type)	☐		Psychiatric	☐	
COPD	☐		Epilepsy	☐	
Diabetes	☐		Stroke	☐	
Drug Abuse	☐		Alcohol Abuse	☐	
Emphysema	☐		Glaucoma	☐	
Alzheimer's	☐		Dementia	☐	
			Other	☐	

Medical History

Condition	Status (Choose one that best describes your condition)
	☐Chronic ☐Resolved
	☐Chronic ☐Resolved
	☐Chronic ☐Resolved
	☐Chronic ☐Resolved
	☐Chronic ☐Resolved

Social History

Exercise

☐None

If you exercise, how frequently? ☐Infrequently ☐_____ Times/Week

If you exercise, what type? ☐Aerobic ☐Non-Aerobic ☐Strength Training ☐Walking ☐Running ☐Swimming ☐Yoga

Caffeine Use Coffee 6 oz/Servings/Day _____Tea 6 oz/Servings/Day_____ Soda/Pop 6 oz/Servings/Day_____

Smoking

☐Not a Smoker ☐Former Smoker ☐10 Plus Cigarettes/Day ☐Less than 10 Cigarettes/Day

☐Daily Pipe Smoker ☐Daily Cigar Smoker

I have smoked for _____ years. I stopped smoking_____(Date)

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Chewing Tobacco
☐Do Not Chew Tobacco ☐Use Moist Powdered Tobacco ☐Use Snuff
I chew _____ times per day. I have chewed tobacco for _____ years.
I stopped chewing tobacco_____ (Date).

Electronic Cigarettes
☐Do not Use Electronic Cigarettes
I have used electronic cigarettes for_____ years. I stopped using electronic cigarettes_____(Date).

Alcohol
☐Never Drink Alcohol ☐Rare ☐Occasional ☐Frequent ☐Binge Drinker ☐In Recovery ☐Quit ☐Abuse History
☐Beer ☐Wine ☐Liquor
I drink _____ drinks per week. I started drinking_____(Date). I quit drinking_____(Date).

Substance Use
☐Never Use Substances ☐Rare ☐Occasional ☐Frequent ☐Addiction ☐Recovering Addict
☐Oral ☐Smoking ☐Intranasal ☐Inhalation ☐Subcutaneous ☐Intravenous
☐Cocaine ☐Methamphetamine ☐Heroin ☐Marijuana ☐Prescription Drug Abuse ☐Other
I use substances _____per week. I stopped using substances _____ (Date).

Environmental History
☐Married ☐Single ☐Divorced ☐Separated ☐Widowed ☐Significant Other
Risk for Domestic Violence ☐Yes ☐No
Occupational History ☐Full Time ☐Part-Time ☐Homemaker ☐Retired ☐Unemployed
Occupational Exposure ☐Chemicals ☐Sounds ☐Overuse Injury ☐Stress ☐Other_____
Occupation: _____
Living Condition ☐Home ☐Nursing Home ☐Home Health Care ☐College ☐Assisted Living ☐Homeless
☐Other_____☐Lives Alone ☐With Spouse/Significant Other
Health Equipment Use ☐Oxygen ☐CPAP ☐BiPAP ☐Nebulizer ☐Wheelchair ☐Walker ☐Cane ☐Shower Chair
☐Bedside Commode ☐Tens Unit
☐From Multiple Birth (twin or triplet etc.) Birth Order _____ (Number)
Number of Children_____
Social Activities ☐Volunteer Work ☐Religious Groups ☐Sports ☐Social Groups
Education ☐None ☐Elementary ☐Some High School ☐High School ☐Some College ☐College ☐Graduate

Sexual History
Are you Sexually Active ☐Yes ☐No
Sexual Orientation ☐Straight or Heterosexual ☐Lesbian, Gay or Homosexual ☐Bisexual ☐Unsure
History of Unsafe Sexual History ☐Yes ☐No
Gender Identity_____

Please enclose in the self-addressed stamped envelope or return to Community Hospital-Fairfax or the Tarkio, Rock Port or Fairfax clinics. Thank you!