COASTAL PINES
MEDICAL GROUP

Patient Intake Form

Name (Last, First, Middle Initial):

_____

DOB: _____ Sex: (Circle One) Male Female

Preferred Phone Number: _____

Email: _____

Home Address: _____

Occupation: _____Marital Status:_____

Emergency Contact: _____Relationship:_____

Emergency Contact Phone Number: _____

Preferred Pharmacy: _____

Previous Primary Care Provider:_____

Please List all Vaccinations

Vaccination:	Year:

Please list all other treating physicians (i.e. cardiologist, orthopedist, dermatologist, ophthalmologist, etc.)

Doctor's Name:	Specialty:

Please list all current medications including OTC, supplements, etc.

Medication:	Dose:	Frequency:

Please list any allergies to medications or other substances (food, pets, etc.) and reactions (rash, hives, anaphylaxis,etc.) _____
_____

Please list all past surgeries and hospitalizations and approximate date

Procedure/Hospitalization:	Date:

Have you ever had any of the following:	Yes	if yes please briefly describe
Breathing/lung Problems		
Arthritis		
Bleeding/Clotting Problems		
Blood Pressure Problems		
Blood Transfusion		
Bowel/Stomach Problems		
Cancer		
Cholesterol Problems		
Diabetes		
Eye Issues (surgery, drops)		
Gynecological Issues		
Heart Disease/Disorder		
Liver Disease		
Neurological Disorder (including headaches)		
Psychiatric Disorder		
Blood clots (PE/DVT)		
Stroke		
Seizure/Epilepsy		
Thyroid Disorder		
Urinary/Kidney Disorder		

Please indicate any major conditions/illnesses that your immediate family members have had

Relative:	Condition and Description:

Smoking Status:

- I am a current smoker, I smoke ___packs/day for the past ___years
- I am currently not a smoker. I have smoked in the past, ___packs/day for ___years
- I have never smoked

Alcohol Consumption:

- Yes. How many drinks and how often?_____
- No.

Ethnicity:

- Decline Response
- Hispanic or Latino
- Not Hispanic or Latino

Race:

- Decline Response
- American-Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Pacific Islander
- Caucasian
- Other: _____

I have completed and agree with the above:

Patient Signature_____

Date_____

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