Central Medical Clinic

New Patient Intake Form

Patient Name: ________________________________

DOB: __________________ DOS: _________________

Please complete all sections:

Reason for Visit: ____
____
____
____

Medical History: Please mark all that apply

Are you or do you think you might be pregnant? Yes, No or N/A

Tobacco Use:

- o Current tobacco user. If Yes, how many packers per day? ________________
- o Former tobacco user. When did you quit? ____________________________
- o Have never used tobacco

If you answered “yes” what kind of tobacco do you use? ___________________________________

Alcohol Use:

- o Daily Limited Use, How many drinks per day? ____
- o History of Alcoholism; How many years have you been alcohol free? _______________________
- o Current Alcoholism. How many drinks do you have per day? _____________________________
- o Socially Drinks Alcohol. How often do you drink? ______________________________________

Illegal Drug Use:

- o No history of illegal drug use
- o Currently using illegal drugs. If so, what kind? ____
- o Currently using Marijuana
- o Currently using someone else’s prescription medication. If so, what kind?
  ____
- o History of illegal drug use? If yes how long has it been? __________________________________
  What kind(s) of illegal drugs did you use? ______________________________________

Have you ever used or abused narcotic or prescription medications? Yes or No

Are you on a restricted prescription plan? Yes or No,

If yes, please document your prescriber ____

Current or Past Medical History: Place an “X” in the appropriate Box

Condition	**Personal**	**Family**
Asthma/Respiratory Condition		
Hypertension		
Head Trauma		
Liver Problems		
Cardiovascular Disease		
Epilepsy		
HIV/AIDS		
Pancreatic Problems		
GI Disease		
Condition	**Personal**	**Family**
Diabetes		
Thyroid Disease		
Nutritional Deficiency		

STD’s		
Condition	**Personal**	**Family**
1.		
2.		
3.		
4.		
5.		
Surgical History	**Year**	

Central Medical Clinic

New Patient Intake Form

Patient Name: ______________________________

DOB: _________________ DOS: ________________

Please List all Current Medications: Please include over the counter medications and vitamins

Medication	Dosage	Frequency

Please List All Known Drug Allergies:

Medication	Reaction

Substance Use History: Please answer ALL of the following questions. Do not Exclude any information; if dates and quantities are not exact please provide an estimate.

Substance	No	Yes Past OR Yes Now	Route	How Much	How Often	Date/Time of Last Use	Quantity Last Used
Alcohol							
Caffeine							
Cocaine							
Crystal Meth-Amphetamine							
Heroin							
LSD or Hallucinogens							
Marijuana							
Methadone							
Pain Killers/Opiates							
Stimulants							
Tranquilizers/Sleeping Pills							
Ecstasy							
Inhalants							
Other:							