Family Health Center of Plainfield LTD.

Patient Intake Form

Name: _____ Birth Date: _____ Phone #: _____
Address: _____ City: _____State:_____ Zip Code: _____
Occupation: _____ Employer: _____
Spouse's Name: _____ Children(s) Name(s): _____

Please list all **allergies** (including Medications, use back of form if necessary)

_____
_____
_____
_____
_____

Past Medical History (please check if you have had for are currently being treated for any of the following:

[ ] Heart Problems [ ] High Blood Pressure
[ ] Asthma [ ] Diabetes [ ] Lung Problems
[ ] Ulcers/Stomach Problems [ ] Thyroid
[ ] Cancer (List type) _____
[ ] Other

Past Surgical History (Please list all previous surgeries)

_____
_____

Have you had a **Tetanus Shot** in the past two years? [ ] Yes [ ] No (The CDC now recommends that all 11 – 64 year olds, especially new parents/key contacts of infants, as well as healthcare workers should receive the new tetanus/diphtheria/whooping cough vaccination in order to protect them against whooping cough.)

Have you had a **Flu Shot** this season? [ ] Yes [ ] No

Current Medications (use back of form if necessary)

Medication	Dose	Medication	Dose

Habits (Please Circle)

Do you smoke cigarettes? [ ] Yes [ ] No
(# of packs/day_____)
Do you smoke a pipe? [ ] Yes [ ] No
Do you smoke cigars? [ ] Yes [ ] No
Do you use chewing tobacco? [ ] Yes [ ] No
Do you regularly use seatbelts? [ ] Yes [ ] No
Do you use recreational drugs? [ ]Yes [ ] No
Do you keep firearms in your home? [ ] Yes [ ] No

Do you drink alcohol? [ ] Yes [ ] No
(Beer, Wine, Hard Liquor, Etc)
_____
Number of glasses/day _____
Number of glasses/week _____

Other physicians seen on a regular basis?

_____
_____
_____
_____
_____

Family History Please indicate a family history of and of the following in your family and who:

Y / N Heart Disease _____ Y / N Stroke _____ Y / N Asthma _____
Y / N Diabetes _____ Y / N High Blood Pressure _____
Y / N Arthritis _____ Y / N Seizures_____ Y / N Arthritis _____
Y / N Liver Disease _____ Y / N Cancer _____
Y / N Other _____

Do you have a Living Will / Durable Power of Attorney for Health Care? [ ] Yes [ ] No

Patient / Legal Guardian Signature: _____ Date _____