GulfView Medical Institute PL
A new approach to health.

New Patient Intake Form

Date: _____

Name: _____ **Date of Birth:** _____

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Other

Social Security Number: _____ **Driver's License Number:** _____ **State:** _____

Home Address: _____ **City:** _____ **State:** _____

Zip Code: _____ **Home Phone:** _____ **Work Phone:** _____

Email: _____

Contact Preference: ☐ Voice ☐ Text ☐ Email

Ethnicity: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian/Pacific Islander Other: _____

How did you hear about us? ☐ Patient Ref. ☐ Website ☐ Physician Ref. ☐ Social Media ☐ _____

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

Northern Address: _____

Insurance Information

Primary Insurance: _____ **ID Number:** _____

Group Number: _____ **Policy Holder Name:** _____

Policy Holder DOB: _____ **Relationship to Policy Holder:** _____

Secondary Insurance: _____ **ID Number:** _____

Group Number: _____ **Policy Holder Name:** _____

Policy Holder DOB: _____ **Relationship to Policy Holder:** _____

Preferred Pharmacy: _____ **Location:** _____

Current Medications (May bring your own list to visit if preferred)

Name of Medication	Strength of Medication	Dosing Instructions

*Note – This information may be taken directly from the pharmacy label on medication.

Allergies

☐ No known allergies ☐ Medication Allergies ☐ Environmental/Seasonal Allergies ☐ Latex Allergy

List Allergies	Reaction

Past Medical History (Check all that apply)

☐ Acid Reflux	☐ Asthma	☐ Glaucoma/Cataracts	☐ Kidney Disease
☐ ADHD	☐ Bleeding Disorder	☐ Headaches	☐ Liver Disease
☐ Alcoholism	☐ Cancer	☐ Hearing loss	☐ Osteoporosis
☐ Allergies	☐ Depression	☐ Heart Disease	☐ Stroke
☐ Anemia	☐ Diabetes	☐ High blood pressure	☐ Thyroid Disease
☐ Anxiety	☐ Emphysema/COPD	☐ High cholesterol	☐ Chronic pain
☐ Arthritis	☐ Epilepsy/Seizures	☐ Irritable bowel	☐ Memory Issues

☐ Other (please list) _____

Past Surgical History

Date of Surgery	Type of Surgery

Family History (Check all that apply)

☐ Asthma	☐ Dementia/Alzheimer's	☐ Depression	☐ Diabetes
☐ Heart Disease	☐ High blood pressure	☐ High Cholesterol	☐ Thyroid Disease
☐ Stroke	☐ Cancer (please specify) _____		

☐ Other (Please list) _____

Social History

Marital Status ☐ Single ☐ Significant Other ☐ Married ☐ Divorced ☐ Widowed

Name of Significant other/Spouse if applicable: _____

Children: ☐ Yes ☐ No Number of sons _____ Number of daughters _____

Name and ages of children: _____

Living Situation: ☐ Live alone ☐ With significant other/spouse ☐ With children/family ☐ Other _____

Occupation: _____

Hobbies/Interests: _____

Tobacco

Have you ever smoked: ☐ Yes ☐ No If yes, what do/did you smoke?_____

Do you still smoke: ☐ Yes ☐ No

If no: How many years ago did you quit? _____ How many years did you smoke? _____

How many packs a day did you smoke? _____

If yes: How many years have you smoked? _____ How many cigarettes do you smoke a day? _____

Have you tried to quit? ☐ Yes ☐ No Are you interested in quitting? ☐ Yes ☐ No

Alcohol

Do you drink alcohol: ☐ Yes ☐ No

If yes, please specify frequency

☐ Daily ☐ Almost Daily (4-6 times a week) ☐ 1-3 times a week ☐ Less than one time a week

Do you drink caffeine? ☐ Yes ☐ No If yes, how many cups a day? _____

Illicit Drugs

Do you use any drugs or prescription medications not prescribed to you? ☐ Yes ☐ No
(Including marijuana, cocaine, amphetamines, pain or anxiety medications, etc)
If yes, please specify type of drug and frequency of use: _____

Diet/Activity

Are you on any special diet? ☐ Yes ☐ No
If yes, how would you describe your diet? (*e.g. Low carb, Low calorie, Renal, Diabetic, Low sodium, low fat, etc.*) _____
Do you currently participate in any regular activity to improve or maintain your physical fitness (*either on your own or in a formal class*)? ☐ Yes ☐ No If yes, please describe: _____

Health Planning

Do you have Advanced Directives in place? ☐ Yes ☐ No
If yes, what directives do you have in place? ☐ Living Will ☐ Durable Power of Attorney ☐ Healthcare Proxy
If no, are you interested in information on Advanced Directives? ☐ Yes ☐ No

Health Maintenance

Please provide the dates and results of the following immunizations, examinations, and tests to the best of your ability. If you have not had one these services please indicate N/A (Not applicable)

Last tetanus booster	☐ Within past 10 years ☐ More than 10 years ago	
Last eye exam	Date: _____	☐ Normal ☐ Abnormal ☐ Unknown
Last hearing exam	Date: _____	☐ Normal ☐ Abnormal ☐ Unknown
Last Sigmoidoscopy/Colonoscopy Or stool test	Date: _____	☐ Normal ☐ Abnormal ☐ Unknown
Last DEXA Bone Scan	Date: _____	☐ Normal ☐ Abnormal ☐ Unknown
Last Pneumonia Vaccine	Date: _____	
Flu Shot this season ☐ Yes ☐ No		

Women:		
Last Pap Smear	Date: _____	☐ Normal ☐ Abnormal ☐ Unknown
Last Mammogram	Date: _____	☐ Normal ☐ Abnormal ☐ Unknown

Men:		
Last Prostate Specific antigen (PSA)	Date: _____	☐ Normal ☐ Abnormal ☐ Unknown
Last Prostate Exam	Date: _____	☐ Normal ☐ Abnormal ☐ Unknown

Concerns: (*Please list any concerns regarding your health in the space provided*)

_____

_____

_____

_____

Patient Name (Printed): _____

Patient Signature: _____ **Date:** _____