ADULT PATIENT INTAKE FORM

Welcome to Healey Medical Practice! We are pleased to serve your health care needs and those of your family. In order to assist our providers and staff, please complete this information to the best of your ability.

Patient Name: ______________________________ Sex: M F Date of Birth: ___/____/____ SS#__________________

Address: ____
Street City/Town State Zip code

Home Phone:_________________Cell Phone:__________________Work Phone:________________Ext.:__________

Emergency Contact:____(____)______________
Name Phone Number

Insurance Carrier: ______________________________ Policy Holder Name: ___________________________________

Policy Number:_______________Your relation to Policy Holder______________ Policy Holder SS#________________

I agree to allow Healey Medical Practice to send a bill for treatment(s) to my insurance carrier:

Patient signature: _______________________________________ **Date**___/____/_____

Former Primary Care Provider: ____(____)_____________
Name Address Phone number

Please list below any specialists you see/have seen, and contact information if possible:

____

____

ADVANCE DIRECTIVES

Do you have a living will? Yes No

Do you have a health care proxy? Yes No Name/Phone# ____

Have you designated someone "Power of Attorney?" Yes No Name/Phone# ________________________________

Have you issued an order indicating "Do Not Resuscitate" (DNR) Yes No

Please give your provider any documentation you have available regarding the above directives.

PAST MEDICAL HISTORY **Check one for each box…….Yes or No**

Condition	Y	N	*Condition*	Y	N	*Condition*	Y	N	*Condition*	Y	N
Chicken Pox			Anxiety			Heart Murmur			Shingles		
Diptheria			Arthritis			Hemorrhoids			Stroke		
Measles			Alzheimer's			Hernia			Thyroid Disease		
Meningitis			Bleeding Disorder			High Blood Pressure			Tuberculosis		
Mononucleosis			Blood Clots			High Cholesterol			**List others below**:		
Mumps			Bronchitis			HIV/AIDS					
Pertussis			Cancer			Intestinal Disorder					
Polio			Cataracts			Kidney Disease					
Rheumatic Fever			COPD/Emphysema			Liver Disease					
Scarlet Fever			Depression			Mental Illness					
Shingles			Diabetes			Migraines					
Strep Throat			Eczema			Motor Vehicle Accident					
Abnormal PAP			Fracture			Multiple Sclerosis					
Acne			Glaucoma			Parkinson's					
ADHD			Heartburn (Reflux)			Pneumonia					
Allergies			Heart Attack			Seizure Disorder					
Anemia			Heart Failure			Sexually Transmitted Disease					

Patient Name____ **Date of Birth** ___/_____/______

Please provide any additional details regarding those condition(s) where you marked "yes":

____

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HEALTH MAINTENANCE HISTORY (**Please indicate date of last exam/test)**

	Date		**Date**		**Date**
Complete Physical Exam		Colonoscopy		Gardasil (HPV) Vaccine	
Pap Smear		Eye Exam		Shingles Vaccine	
Mammogram		Tetanus		EKG	
Bone Density Scan		Pneumovax		Chest X-ray	
PSA test (prostate blood test)		Influenza		Dental Exam	
Rectal Exam		TB test			

Allergies **(include reaction):**

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Medications **(Includes birth control, over the counter, vitamins, supplements, and herbal remedies)**

Name Dose Frequency Reason For Use

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____

____

____

____

Surgeries

Year Procedure Surgeon Facility

____

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____

Patient Name____ **Date of Birth** ___/_____/______

Hospitalizations

Year Reason ___________________________ Facility (Name and address if out of local area)

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____

____

Obstetric/Gynecologic History For Women

Age of first menstrual period _____ Last menstrual period _____ Period Frequency _____ #of days____

Age of menopause ______

Total Number of Pregnancies _____ Number of Living children _______

Full Term ____ Premature ____ Miscarriages ____ Abortions _____

Personal Background

Highest Education level completed: Grade school _____ High school____ College____ Graduate degree _____

Marital Status: Single ____ Married ____ Divorced ____ Widowed ____ Separated ____

Occupation:_________________________________ Employer:____

Unemployed ____ Retired_____ Disabled _____ Cause of Disability: _______________________________________

Tobacco Use: Yes __ No__ Former ___ Type__________ #Years _____ # Packs/Day____ # Year Quit______
Alcohol Use: Yes __ No__ Former ___ Type ______ Amount_________ Frequency________ Abuse Yes/No
Drug Use: Yes __ No__ Former ___ Type ________________ IV Drugs - Yes/No Rehab - Yes/No

Family History

Adopted ____ Unknown____ **Please list below any pertinent medical illnesses in your family**.

Father ____ Mother _______________________________________

Brother(s) ____ Sister(s) ______________________________________
____ ______________________________________

Paternal Grandfather ______________________________ Paternal Grandmother _________________________

Maternal Grandfather ______________________________ Maternal Grandmother _________________________

Additional family members – not listed above: ____

____

I have completed this Adult Intake Form to the best of my ability -

Signature of Patient: ____ **Date:** ___/___/_____