Patient Intake Form

We recognize this is a long form and requires lots of information, the more complete you are able to have this form for us the easier it will be to provide comprehensive care.

Patient Name: _____
Date of Birth (dd/mm/yyyy):_____
PHN (on carecard): _____

Current/ongoing medical conditions *(e.g. high blood pressure, high cholesterol, irritable bowel syndrome, depression, etc.)*:

_____
_____
_____
_____
_____

Previous/resolved medical conditions *(e.g. childhood asthma, eczema, broken wrist, etc.)*:

_____
_____
_____

Surgeries/procedures or Hospitalizations *(please include the year and details of any time you had surgery, or were admitted to the hospital overnight)*:

_____
_____
_____
_____
_____
_____
_____

Prescription Medications *(include name of medication, dose/strength, and how often you take it, e.g. lipitor 10mg once per day, ramipril 5mg two times per day)*:

_____
_____
_____
_____
_____
_____
_____

Over the Counter and Herbal Products:

_____
_____
_____

Allergies *(include the trigger and the reaction you get, e.g. penicillin - rash, peanuts - hives)*:

_____
_____

Smoking History:
[ ] Never smoked
[ ] Previous smoker - How many years & Avg # cigarettes _____
[ ] Current Smoker - Number of cigarettes per day & how many years _____

Alcohol Use: Number of drinks/week: _____
Additional Substance Use: _____

Name and Contact Information of Specialists Involved in Your Care:
_____
_____
_____
_____
_____

Family medical history (parents, siblings and children are most relevant)
(Please indicate family member and age at diagnosis):

Heart disease, heart attack: [ ]NO [ ]YES
Family Member and Age at Diagnosis: _____

Stroke: [ ]NO [ ]YES
Family Member and Age at Diagnosis: _____

High blood pressure: [ ]NO [ ]YES
Family Member and Age at Diagnosis: _____

Diabetes: [ ]NO [ ]YES
Family Member and Age at Diagnosis: _____

Thyroid disorder: [ ]NO [ ]YES
Family Member and Age at Diagnosis: _____

Breast, ovarian, colon or prostate cancer: [ ]NO [ ]YES
Family Member and Age at Diagnosis: _____

Mental Illness *(e.g. anxiety, depression, bipolar, schizophrenia)*: [ ]NO [ ]YES
Family Member and Age at Diagnosis: _____

Other: _____

Children *(please list names, gender, year of birth & any serious illness)*:
_____
_____
_____

Relationship Status: _____

Current or Previous Occupation: _____

Previous Family Doctor's Contact Information:
_____

Pharmacy Contact Information:
_____

Emergency Contact & Relation:
_____

Other Information You Would Like Us to Know:
_____
_____
_____

Is there anyone you would like us to be able to share information about your health with? Please let us know so we can get appropriate consent and include this information on your chart.
Please also let us know if you have a medical POA or have had discussion around goals of care.

Finally, please bring all your **medications** and **immunization records** for your first appointment.

You can email the finished form to intake@ballemmedical.com