Meeker Family Health Center

Phone: (970) 878.4014 – Fax: (970) 878.0019
100 PMC Drive, Meeker, CO 81641
Eastern Rio Blanco County Health Service District

Patient Intake and History Form

Name:_____ **Date of Birth**_____

Occupation:_____ Employer:_____
Marital Status: Single Partner/Married Divorced Widowed Other:_____
Spouse/partner's name:_____
Who lives at home with you?_____
Number of children/ages:_____ Years of education/highest degree:_____

GENERAL MEDICAL HISTORY

	None	Self	Mother	Father	Sibling	Your Child	Grandparent	Aunt/Uncle
Alcoholism	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis/Lupus	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Blood disorder	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐	☐	☐	☐	☐
Mental disorder	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐
Seizure disorder	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐	☐	☐	☐	☐

Do you smoke/use tobacco ☐No ☐Yes How long?_____ How many per day_____

Do you drink alcohol? ☐No ☐Yes How many drinks per week?_____

Do you use recreational/illegal drugs? ☐No ☐Yes What and how long?_____

Allergy History:

List of known allergies (including medication allergies) and reaction to allergen. Or check one of the boxes:

☐No Known Allergies (NKA) ☐No Known Drug Allergies (NKDA)

_____

_____

What was the month and year of your last physical exam?_____

What was the month and year of your last:

Colonoscopy:_____ Never/Normal/Abnormal

Mammogram:_____ Never/Normal/Abnormal

Pneumonia Shot:_____

Prevnar 23_____

Bone Density Study:_____ Never/Normal/Abnormal

Pap Smear:_____ Never/Normal/Abnormal

Tetanus Shot:_____

Zostavax (Shingles) Vaccine:_____

Have you had any surgery? List what surgeries you have had and the year you had it:

_____

_____

_____

_____

Medication History:

What medications do you take? Please include vitamins and supplements.

Name of Medication	**Dose, # of times/day**	**What is it for?**

Preferred Pharmacy:_____

Do you use a mail order pharmacy?_____

Preferred Mail Order Pharmacy_____

Please be sure we have your pharmacy provider information and a copy of your prescription drug card.

Do you currently follow up with any other Provider/Specialist? Please indicate name.

Cardiology_____ Neurology_____ Urology_____

Endocrinology_____ Nephrology_____ Optometry_____

Orthopedics_____ ENT_____ Therapy_____

Mental Health_____ Infection Disease_____ Gynecology_____

Pulmonologist_____ Oncology_____ Hepatology_____