Internal Medicine of Brighton, PLLC

New Patient Intake Questionnaire Today's Date _____

Name:_____ Date of Birth: _____

Do you see any other Doctors? (Please include Dentist, Eye doctor, GYN, Therapist, Chiropractor, and any other specialists you see) :

_____

_____

_____

_____

Please list any surgeries you have had and the date of those surgeries:

_____

_____

_____

_____

Do you have any barriers to communication? (hearing aids, language, etc.) _____

Family History:

Do you or anyone in your family have the following?:

	Self	Mother	Father	Sisters	Brothers	Grandparents			
						Mat GM	Mat GF	Pat GM	Pat GF
Diabetes									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Asthma									
Depression									
Anxiety									
Clotting Disorder									
Autoimmune Disorder									
Cancer									
Type									
Age at onset									

Personal History:

Marital Status:_____

Who do you live with? _____ Do you have any Pets?_____

Occupation:_____Education:_____

Do you have any religious beliefs that could affect your care? _____

How would you classify your illicit substance use?: (Circle one) :

Current every day Current Somedays In the Past Never

If you answered every day, some days, or in the past please list what illicit substances you use(d):

_____

Are there Smoke/Carbon Monoxide Detectors in home? (Circle one) Y or N.

Do you have weapons in your home? (Circle one) Y or N.

If yes, list what_____

If yes- Are they locked in a safe? (Circle one) Y or N.

Do you wear a seatbelt in the car? (Circle one) : Always Most of the time Never

Do you smoke cigarettes? (Circle one) Y or N. If yes, how many per day? _____. If you have Quit-

How long ago?_____ How long did you smoke for? _____

Are you at Risk for Second Hand Smoke? (Circle one) Y or N.

Do you drink alcoholic beverages? (Circle one) Y or N If yes, _____ x per week, ____ drinks per setting

	Sexual Orientation: (check one)		Gender Identity: (check all that apply)
	Lesbian, Gay, or Homosexual		Identifies as Male
	Straight, or Heterosexual		Identifies as Female
	Bisexual		Female-to-Male(FTM)/Transgender Man
	Something else (please describe)		Male-to-Female(MTF)/Transgender Female
	Don't know		Gender queer
	Choose not to disclose		Other (please describe)
			Choose not to disclose

Medications: Please list all medications you are taking for any reason (include non-prescription):

Drug Name:	Dose:	How Often?

If you need more room, please finish on the back of this paper.

List your allergies and reactions:

Allergy	What happens?

If you need more room, please finish on the back of this paper.