OCEANSIDE MEDICAL
HEALTH | AESTHETICS | LIFESTYLE

PATIENT INTAKE FORM

Last Name: ______________________________ First Name: _______________________________M.I. ______

Preferred Name: __________________________ Date of Birth: ______________________________________

Preferred Phone Number ___________________ Cell ___ Home ___ Work ___

Address ____

Email ____

Primary Insurance: _________________________________ Subscriber Number: ________________________

Secondary Insurance: _______________________________ Subscriber Number: ________________________

Pharmacy Address ____

YOUR MAJOR HEALTH CONCERNS OR QUESTIONS

What major concerns do you have or wish to discuss for your visit?

____

____

____

MEDICATIONS

List below all the medications that you take regularly or have taken regularly in the past month (including aspirin products, over the counter medications, vitamins, birth control pills, etc.):

Medication	**Strength**	**How often do you take it?** (once per day, etc)	**How long have you been taking this medication**

Patient Name: ___________________________________ Patient DOB: ____/_____/_______

Allergies: List any drug allergies (if any, briefly describe the reaction):_________________________________

____

Are you allergic to antibiotics (such as penicillin or sulfa)? Yes ______No_____

Adverse Reactions: List any adverse reactions to medications (nausea, change in mental status):

____

____

____

Please answer the following questions regarding your Sexual Orientation and Gender Identity:

Birth Sex: ___ Male ___ Female ___ Unknown

What is your Gender Identity?

___ Male ___ Female

___ Female-to-Male (FTM) /Transgender Male/Trans Man

___ Male-to-Female (MTF) / Transgender Female/Trans Woman

___ Genderqueer, neither exclusively male nor female

___Other: ____

___ Choose not to disclose

What is your Sexual Orientation?

___ Lesbian, gay, or homosexual ___ Straight or heterosexual ___ Bisexual

___ Do not know ___ Choose not to disclose ___ Other: ________________________________

What is your current relationship status?

___ Single ___ Partner ___ Married

Please place a check mark next to the highest level of education you obtained in school:

____ Elementary ____ High School ____ College ____ Other: ____________________________

Patient Name: ________________________________ Patient DOB: ____/_____/_______

PAST MEDICAL HISTORY

Place a check mark on the line next to the illness or illnesses that you currently have or have had in the past:

____ADD/ADHD	____Fibromyalgia	___High cholesterol
____Anemia	____ Gallstones	___Irritable Bowel
____Arthritis	____ Glaucoma	___Kidney disease
____Asthma	____ Gout	___Liver disease/Cirrhosis
____Autoimmune	____ Heartburn/Reflux	___Mental Illness
____Cancer	____ Heart attack	___Migraine
____Diabetes	____ Hepatitis	___Seizures
____Depression	____ High blood pressure	___Stomach Ulcer
____Emphysema/COPD		____Thyroid Problem

Surgeries (include year)

____

____

____

Serious past injuries (describe the type of injury and approximate dates of occurrences):

____

____

____

Hospitalizations (other than for surgery)

____

____

____

Patient Name: ___________________________________ Patient DOB: ____/_____/_______

HEALTH MAINTENANCE

Vaccines

When was your last tetanus booster? ______________________________

Have you had a flu (influenza) vaccine in the last 12 months? Yes No

Have you had a pneumonia vaccine in the last 12 months? Yes No

Have you ever had a shingles vaccine? Yes No

Screenings

Do you have eye exams regularly? Yes______ No ___

Where and when was your last eye exam? ____________________________

Do you have dental exams regularly? Yes____ No ___

Where and when was your last dental exam? __________________________

Have you ever had a colorectal cancer screening (colonoscopy)? Yes ___ No ___

If yes, please tell us when and where, and any findings if known:

____

What is your usual weight? _____ What was your approximate weight one year ago? _____

What is your present weight? _____

WOMEN:

Name and address of your GYN Provider:

____

Have you had a "Pap" smear in the last two years? Yes ___ No ___

Have you ever had a Mammogram? Yes ___ No ___

If yes, where and when was your last scan? __________________________

Have you ever used birth control pills? Yes ___ No ___

Obstetrical History: Number of pregnancies: __________ Number of deliveries: __________

Please tell us about any other Specialists you see: List the name, location, and how often you see them:

____

____

____

____

____

____

____

Patient Name: ___________________________________ Patient DOB: ____/_____/_______

FAMILY HISTORY

Is your mother living? Yes __No __ (cause of death and age at death) ______________________________

Is your father living? Yes __ No __ (cause of death and age at death) ______________________________

Do you have any siblings? Yes __ No__ (cause of death and age at death) ____________________________

Do you have any children? Yes __ No __ (cause of death and age at death) ___________________________

Have any family members, either living or dead, ever had any of the following diseases? If yes, indicate who

__ Alcoholism ______________________ __Heart attack (include age) ___________________

__High blood pressure ________________ __Diabetes ______________________________

__Breast cancer_____________________ __ Ovarian cancer __________________________

__Colon cancer _____________________ __ Kidney disease __________________________

__Osteoporosis_____________________ __ Hemophilia ____________________________

__Tuberculosis _____________________ __ Mental Illness __________________________

__Other __________________________

SOCIAL HISTORY AND HABITS

Do you drink alcoholic beverages (wine, beer, liquor, etc.)? Yes __ No __

If yes, how many alcoholic beverages do you have on average in a week? _____ per week? _____

Do you smoke? Yes __No__

Do you smoke cigarettes Yes__ No__ Pipe tobacco Yes__ No__ Vape products Yes__ No__

If no, have you ever smoked? Yes __No __

Please tell us how many years you have/had been a cigarette smoker: ______ year(s)

Have you ever tried to quit smoking? Yes __ No __

Do you use any recreational/ilicit drugs? Yes __ No __

How many days per week do you exercise for at least 20 minutes? _____ days per week

Are you sexually active? Yes __ No __

What method of contraception do you use? Birth control pill __ Condom __ Diaphragm __ Other: ____

Have you ever been diagnosed with a sexually transmitted disease? Yes __ No __

Patient Name: ___________________________________ Patient DOB: ____/_____/_______

CONTACT INFORMATION FORM

Emergency Contact Information

In the event of an emergency, we will use this information to notify your preferred contacts:

Primary Contact Person:

Name: ___________________________________ DOB: _____ / _____ / _______________

Relationship to patient: ____

Home Phone: _______________ Cell Phone: _______________ Work Phone: _______________

Secondary Contact Person**:**

Name: ___________________________________ DOB: _____ / _____ / _____

Relationship to patient: ____

Home Phone: _______________ Cell Phone: _______________ Work Phone: _______________

Permission to Discuss

I, the undersigned, hereby give Oceanside Medical permission to discuss my medical information with:

Name #1: ______________________________________ Relationship: _____________________

Home Phone: _______________ Cell Phone: _______________ Work Phone: _______________

Name #2: ______________________________________ Relationship: _____________________

Home Phone: _______________ Cell Phone: _______________ Work Phone: _______________

Please list any exclusions to discuss such as test results, psychiatric disorders, history of treatment for drug or alcohol abuse, HIV/AIDS, etc:

____

____

____

Patient/Legal Guardian Signature: ____

Date: _____ / _____ / __________