North Texas Family Health
Patient Intake

2021 revised (PDF)

Last Name: _____ First Name: _____ MI: ___

Nick name or preferred name: _____ Date of Birth: _____

Past Medical History: (mark the applicable boxes)

Head

☐Trauma

Eyes

☐Blindness ☐Cataracts ☐Glaucoma ☐Wears glasses/contacts

Ears

☐Hearing aids

Nose/Sinuses

☐Allergic Rhinitis ☐Sinus Infections

Mouth/Throat/Teeth

☐Dentures

Cardiovascular

☐Aneurysm ☐Angina ☐DVT ☐Dysrhythmia ☐HTN ☐Murmur ☐Myocardial Infarction
☐Other Heart Disease

Respiratory

☐Asthma ☐Bronchitis ☐COPD ☐Pleuritis ☐Pneumonia

Gastrointestinal

☐Cirrhosis ☐GERD ☐Gallbladder Disease ☐Heartburn ☐Hemorrhoids ☐Hepatitis ☐Hiatal Hernia
☐Jaundice ☐Ulcer

Genitourinary

☐Hernia ☐Incontinence ☐Nephrolithiasis ☐Other Kidney Disease ☐STDs ☐UTIs

Musculoskeletal

☐Arthritis ☐Gout ☐M/S Injury

Skin

☐Dermatitis ☐Mole(s) ☐Other Skin Conditions ☐Psoriasis

Neurological

☐Epilepsy ☐Seizures ☐Severe Headaches/Migraines ☐Stroke ☐TIA

Psychiatric

☐Bipolar Disorder ☐Depression ☐Hallucinations/Delusions ☐Suicidal Ideation ☐Suicide Attempt

Endocrine

☐Goiter ☐Hyperlipidemia ☐Hypothyroidism ☐Thyroid Disease ☐Thyroiditis ☐Type 1 DM
☐Type 2 DM

Heme/Onc

☐Anemia ☐Cancer

Infectious

☐HIV ☐STDs ☐Tuberculosis

Custom

☐Abnormal Chest X-Ray ☐Abnormal EKG ☐Acid Reflux ☐ADD/ADHD/Dyslexia ☐Addiction ☐Anger Issues ☐Anxiety ☐Chest Pain ☐Concussion ☐Ear Infections ☐Erectile Dysfunction ☐Estrogen Disorder ☐Fainting Foot Problems ☐Fractures ☐Hearing Loss ☐Insomnia ☐Memory Loss ☐Motion Sickness ☐Ovarian Cyst ☐Recurrent Back Pain ☐Sleep Apnea

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Medication	Dosage	Frequency	Reason for Taking
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Surgery and Location	Year	Complications
1		
2		
3		
4		
5		

Social History

Tobacco

☐Current Everyday Smoker ☐Current Someday Smoker ☐Former Smoker ☐Heavy Smoker ☐Light Smoker ☐Never Smoked ☐Smoke Status Unknown

Alcohol

☐Do Not Drink ☐Drink Daily ☐Frequently Drink ☐Hx of Alcoholism ☐Occasion Drink

Drug Abuse

☐IVDU ☐Illicit Drug Use ☐No Illicit Drug Use

Cardiovascular

☐Eat Healthy Meals ☐Regular Exercise ☐Take Daily Aspirin

Safety

☐Household Smoke Detector ☐Keep Firearms in Home ☐Wear Seatbelts

Sexual Activity

☐Exposure to STI ☐Homosexual Encounters ☐Not Sexually Active ☐Safe Sex Practices ☐Sexually Active

Birth Gender

☐Male ☐Female ☐Undifferentiated

Custom

☐Smokeless Tobacco ☐Vape/E-cig

Family History

	Health Status	Medical History
Mother	☐Alive ☐Deceased	☐Arthritis ☐Asthma ☐Bleeding Disorder ☐CAD ☐COPD ☐Diabetes ☐Heart Attack ☐Heart Disease ☐High Cholesterol ☐Hypertension ☐Mental Illness ☐Osteoporosis ☐Stroke ☐Cancer ☐Addiction ☐Alcoholism ☐Dementia/Alzheimer's ☐Depression ☐Migraines
Father	☐Alive ☐Deceased	☐Arthritis ☐Asthma ☐Bleeding Disorder ☐CAD ☐COPD ☐Diabetes ☐Heart Attack ☐Heart Disease ☐High Cholesterol ☐Hypertension ☐Mental Illness ☐Osteoporosis ☐Stroke ☐Cancer ☐Addiction ☐Alcoholism ☐Dementia/Alzheimer's ☐Depression ☐Migraines
Maternal Grandmother	☐Alive ☐Deceased	☐Heart Attack ☐Stroke ☐Cancer ☐Dementia/Alzheimer's
Maternal Grandfather	☐Alive ☐Deceased	☐Heart Attack ☐Stroke ☐Cancer ☐Dementia/Alzheimer's
Paternal Grandmother	☐Alive ☐Deceased	☐Heart Attack ☐Stroke ☐Cancer ☐Dementia/Alzheimer's
Paternal Grandfather	☐Alive ☐Deceased	☐Heart Attack ☐Stroke ☐Cancer ☐Dementia/Alzheimer's

Allergies

Medication/Substance	Type of Reaction
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Pharmacy (please list preferred pharmacy on top line followed by additional pharmacies to be used)

Name of Pharmacy	City/Town	State	Phone Number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Explanations: (please use the space below to explain or add any necessary information not mentioned above)

_____

_____

_____

_____