PATIENT INTAKE FORM

Medical History:

_____
_____
_____
_____
_____
_____

Surgical History:

_____ Year: _____

_____ Year: _____

_____ Year: _____

Allergies:

_____
_____
_____

Medications:

_____
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_____
_____
_____
_____
_____

Immunization History:

_____
_____
_____
_____

Significant Family History:

_____
_____
_____
_____

Social History:

Alcohol: □ Yes □ No

Smoker: □ Yes □ No

Drugs: □ Yes □ No

If any are checked yes, provide explanation if needed:

_____
_____
_____
_____

Any other pertinent information that you would like the provider to know about:

_____
_____
_____
_____
_____
_____
_____