

Dr. Susan C. King
1907 Cypress Creek Road Suite 104
Cedar Park, Texas 78613

Welcome To Our Office!

Name: _____ Today's Date: _____
 First Middle Last

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone () _____ Cell Phone () _____

Email Address: _____ May we send information here? Y/N

Birth date: _____ Age: _____ SSN: _____

Employer: _____ Years there _____

Employer's Address _____

City: _____ State: _____ Zip: _____ Occupation: _____

Work Phone () _____

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: _____ Relationship to Patient: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone () _____ Cell Phone () _____

Email Address: _____ May we send information here? Y/N

Birth date: _____ Age: _____ SSN: _____

Employer: _____ Years there _____

Employer's Address _____

City: _____ State: _____ Zip: _____ Occupation: _____

Work Phone () _____

Name of Spouse: _____ Birth date: _____ Age: _____

Employer: _____ Years there _____

Employer's Address _____

City: _____ State: _____ Zip: _____ Occupation: _____

Work Phone () _____ SSN: _____

In case of emergency, contact: _____ Relationship _____

Home Phone () _____ Work Phone () _____

How did you learn about our practice? _____

Do you wish correspondence to be confidential? YES NO

Do you wish phone calls to be confidential? YES NO

May we contact you at work? YES NO

Family Practice New Patient Intake Form

Reason for Visit _____

Past Medical History:

Please review the list below and check any problems you have had now or in the past

Abnormal Pap Smear	
Acne	
ADD/ADHD	
Alcohol Abuse	
Anemia	
Anxiety Disorder	
Asthma	
Bipolar Disorder	
Blood Clot	
Blood Transfusion	
Cancer (What kind)	
Chronic Bronchitis	
Crohn's Disease or IBS	
Colon Polyps	
Depression	
Diabetes	
Diverticulitis	
Drug Abuse	
Eating Disorder	

Eczema	
Emphysema	
Frequent UTI's	
Freq Sinus Infections	
Gallstones	
Glaucoma	
Gout	
Heart Attack	
Heart Condition (specify)	
Hepatitis (specify A, B, C)	
High Blood Pressure	
High Cholesterol	
Kidney Disease	
Kidney Infections	
Kidney Stones	
Lupus	
Melanoma or Skin Cancer	
Migraines	
Osteoarthritis	

Osteopenia	
Osteoporosis	
Positive TB Skin Test	
Prostate Problems	
Psoriasis	
Reflux (heartburn)	
Rheumatoid Arthritis	
Rosacea	
Seasonal Allergies	
Seizures	
Sexually Trans. Disease (specify)	
Stomach Ulcers	
Stroke	
Tuberculosis	
Thyroid Disease	
Ulcerative Colitis	
Warts	

Other medical problem not on list
: _____

Please check or list all of the **SURGERIES** you have had:

Type of surgery:	Year
Appendectomy	
Arthroscopy (joint)	
Back or Neck Surgery	
Cataract Surgery	
Cesarean Section	
Gallbladder Removal	
Heart Surgery (specify)	
Hemorrhoids	
Hernia	

Type of surgery:	Year
Hysterectomy	
Knee or Hip Replacement	
Mastectomy or Lumpectomy	
Mastectomy/Lumpectomy	
Polyp Removal (colon)	
Tonsillectomy/Adenoidectomy	
Tubal Ligation or Vasectomy	
Plastic Surgery (specify)	
Other (specify)	

Current Medications:

(please include over the counter medications and food **supplements**)

Drug Name:	Dose:	How Often?

Drug Name:	Dose:	How Often?

Are you **ALLERGIC** to any medications? **Yes No**

Drug Name:	Reaction:

NAME: _____

For Women:

Last menstrual period	/ /
Last pap smear n/a	/ /
Last mammogram n/a	/ /
Last bone density	/ /

Age of first period	
# of days in cycle	
# of days in flow	
Are you menopausal	Y N
Age at onset of menopause	

# of pregnancies	
# of live births	
# of miscarriages	
# of abortions	
# of living children	

Family History: Have any of your family members had any of the following problems?

X	Condition:	Family Member:	X	Condition:	Family Member:
	Heart Disease/attack			Osteoporosis	
	Stroke			Migraines	
	Diabetes			Breast Cancer	
	High Blood Pressure			Colon Cancer	
	High Cholesterol			Prostate Cancer	
	Thyroid Disease			Lung Cancer	
	Depression			Ovarian Cancer	
	Other Mental Illness			Uterine Cancer	
	Alcoholism			Skin Cancer	
	Asthma			Other Cancer	

Any other illness in the family not listed?

Social History:

Marital Status (circle one): Single Engaged Married Separated Divorced Widowed

Highest Level of Education: <6th grade Jr. High High School College Graduate school Professional

Occupation:

If you have any children, please list their names and ages:

Health Habits:

1. Do you **smoke currently?** Yes No If so, how much? ___ cig/d # of years smoking

_____ If no, did you **smoke in the past?** Yes No How many years? ___ How much? ___pk/d quite date

Are you **exposed to smoke?** Yes No
 Any other tobacco use?

Yes No type: Cigars chewing tobacco snuff other

2. Do you drink **caffeine**? **Yes No** If so, how much?

3. Do you drink **Alcohol**? **Yes No** What kind? Beer Wine Liquor
Other: _____
If so, how many times per week? _____ month? _____ year? _____
Have you ever had a problem with alcohol in the past? (legal or social)

4. Have you ever used **street drugs**? **Yes No**
Which ones? Marijuana IV drugs amphetamines cocaine heroin downers inhalants other

- Are you still using? **Yes No** Which ones? _____
5. Are you **sexually active** (in the last year)? **Yes No**
If yes circle all that apply: **1 partner multiple partners**
Male partner(s) Female partner(s)
Which birth control do you or your partner use? None condoms the pill vasectomy/tubal
other _____
6. Do you **exercise**? **Yes No** If so, what type and how often?

7. Do you eat out at **restaurants** weekly? **Yes No** Times per week _____
8. How many servings of **fruits and vegetables** do you get per day? 0 1 2 3 4 5 >5
9. Do you take a **calcium supplement**? **Yes No** Number of dairy servings per day: ____ (milk
cheese yogurt..)
10. Do you wear a **seatbelt**? **Yes No**
11. Do you have a **living will** (do not resuscitate, medical power of attorney)? **Yes No** Please ask
for info
12. Is there concern for your **safety**? (emotional, physical, or sexual abuse)? **Yes No**

NAME: _____

