Pendleton Primary Care Clinic

Medical Intake Form

Patient Name: _____ Date of Birth: _____ Today's Date: ___/___/___

Allergies/Intolerances ☐ No known allergies

Allergy	Allergic Reaction

Personal Medical History

Disease/Condition	Current	Past	Comments
Alcoholism/Drug Abuse			
Asthma/COPD			
Cancer (type:_____)			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes (type:_____)			
Heart Disease			
High Blood Pressure (hypertension)			
High Cholesterol			
Kidney Disease			
Migraine Headaches			
Osteoporosis/Osteopenia			
Thyroid Disease			
Stroke			
Other: _____			
Other: _____			

Surgical History ☐ No previous surgeries

Surgery Type *(Specify Left/Right)*	Date	Location/Facility

Patient Name: _____ Date of Birth: _____

Family Medical History ☐ No significant family history is known

✓ Check All That Apply	Alcoholism/Drug Abuse	Cancer type:_____	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Heart Disease	High Blood Pressure	High Cholesterol	Lung Disease	Thyroid Disease	Kidney Disease	Migraines	Stroke	Other:_____
Mother														
Father														
Brother														
Sister														
Child														
MGM														
MGF														
PGM														
PGF														
Other: _____														

Other Health Issues

Tobacco Use	Smoke Cigarettes Y N Other: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew ☐ Vape
Current: Packs/Day: ____ # of Years: ____ Past: Quit date: _____ Packs/day ____	
Alcohol/Drug Use	Do you drink alcohol Y N ☐ Beer ☐ Wine ☐ Liquor # of Drinks/week ___
Marijuana use ☐ Past ☐ Current Other recreational drugs ☐ Past ☐ Current	

Medications

Medications *(Please List All)*	Dose *(Mg., Pill, Etc)*	Times Per Day	Prescriber

Please list additional medications on a blank sheet of paper with the required information

Other Providers/Specialists

Provider	Name	Last Visit