PATIENT MEDICAL HISTORY INTAKE FORM

Patient information

FOR OFFICE USE ONLY

PROVIDER: NB JG MG KK TM GAM JM KP BP DR CR AS AW HB MC VC EH HIE KR KS LOCATION: BMC MMC PEC INT OFFICE DATE: _____

***	PLEASE	COMPL	ETE AND	MAIL	BACK ASAP	***

Reason for visit	
Patient Full Name	
Date of Birth	Age
Referring provider	Primary care provider
Race	O Decline to specify
Ethnicity	O Decline to specify
Sex OMale OFemale OOther Pr	referred Pronoun OHe OShe OThey/Them
Primary/Preferred Language O English	Other:
Preferred Pharmacy	
Current Medications ONO current med	lications
Name Dose	
1	
2	
3	
4	
5	
6	
7	
8.	
9.	
10	
Allergies OPatient has no known allergies	Patient has no known drug allergies
67	
1	
2	
3	
4	
5	

PLEASE COMPLETE ALL PAGES - FRONT AND BACK

Social Histor	•			Employ	/er			
Marital Status Spouse name, if a		-	OMarried	O Divorced	Owi	dowed	Civil Union/	Long Term Partner
Tobacco Use	OCur	rent	O Former	ONever		Type/ye	ars of use	
Alcohol O Current O Former			ONever		Number drinks/week			
Drug Use O None O Marijuana, f			requency Other					
Past or Present Medical Conditions Blood			None Bleeding Disorders, specify					
Cardiac		O Aor	al Fibrillation tic Stenosis er Valvular Disea	High Blood Pressure Heart Attack Blood Clot (DVT, Pulmonary Hypertension Congestive Heart Failure se, type				O Blood Clot (DVT/PE) Heart Failure
Endocrine		O Dia	betes		sease			
Gastrointestina	I	Celi Cirr Cole	rett's Esophagus ac Disease hosis on Cancer on Polyps	Crohn's Di Diverticulo GERD/Refl Hepatitis E Hepatitis C	osis/itis ux 3		Pylori itable Bowel (IBS) ctose Intolerance ver Disease	 Pancreatic Cancer Pancreatitis Stomach Ulcer Ulcerative Colitis
Pulmonary		O Ast	hma	O COPD/Emp	hysema	◯ Sle	ep Apnea	
Neurology		O Der	nentia	O Seizure Dis	order	O Pa	rkinson's	OStroke
Psychiatric			liety		l	Орт	sd Oalc	ohol Abuse Disorder
Rheumatology			us (SLE)			○ Rh	eumatoid Arthritis	;
Urinary		◯ Chr	onic Kidney Disea	se		Оне	modialysis	O Peritoneal Dialysis
Oncology		O Can	icer, type					_
Other Condition	n(s)							

If you have Ulcerative Colitis or Crohn's Disease, please provide immunization information

Influenza		Pneumococcal		COVID	
Shingles		Tdap/Td		Hepatitis B	
HPV					
O Last TB Screening, when? O Hep B Screening, when?					

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Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies. O Yes O No

Consent to Share Data

I consent to having my medical and non-identifying demographic information shared with other health care entities. Example: Health data banks or Medical Registries for the purpose of research in health care trends such as the American Gastroenterology Association

O Yes O No				
Patient Care Reminder Preference I would like to receive preventative care and for Example: Colonoscopy Recall	ollow up care rer	ninders.	🔿 Yes	O No
Care Reminder Contact Preference	OEmail	O Patient Declir	ies to specify	O Other: