First in Primary Care Broadway MEDICAL CLINIC

NEW PATIENT INTAKE AND PHYSICAL FORM

Patient Name _____ **Date of Birth** _____

Preferred Pronouns **[ ] She/her [ ] He/him [ ] They/them [ ] Other**

Occupation and Employer _____

Who lives at home with you? _____

Medical problems (past and current):

[ ] Allergies	[ ] COPD	[ ] High cholesterol
[ ] Anemia	[ ] Depression	[ ] irritable bowel
[ ] Anxiety	[ ] Diabetes	[ ] Kidney disease
[ ] Arthritis	[ ] Headache	[ ] Osteoporosis
[ ] Asthma	[ ] Heartburn	[ ] Seizures
[ ] Blood clots	[ ] Heart Disease	[ ] Stroke
[ ] Cancer	[ ] High Blood Pressure	[ ] Thyroid disease

Other medical problems: _____

_____

Surgeries (include approx dates): _____

_____

Current medications (incl. vitamins/herbal supplements): _____

_____

_____

What issues would you like to discuss today? _____

_____

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Family History (diabetes, high blood pressure, cancer, autoimmune conditions):

[ ] Unknown or adopted

Relation	Age	Age at Death	Medical History
Mother			
Father			
Brother			
Brother			
Sister			
Sister			
Mother's Father			
Mother's Mother			
Father's Father			
Father's Mother			
Child			
Child			
Other _____			
Other _____			