Health Intake Form

Patient Name_____ **Date of Birth**_____

Allergies

( ) No known drug allergies ( ) No known allergies

Allergic to:	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medications

Name of Medication:	Dose:	Frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History

Alcohol consumption: ( ) daily ( ) socially ( ) rarely

Drinks per week: _____ If quit drinking, when? _____

Smoking:

( ) Never Smoked

( ) Quit Smoking, When?_____ How much did you smoke? ____packs/day For how many years?___

( ) Current Smoker _____packs/day for _____years

Approximate day of last colonoscopy (if applicable): _____

Do you have Advanced Directives (i.e.: living will, healthcare power of attorney)?

_____

Previous treating provider (in case we need medical records):

Name _____

City _____ State _____

Phone Number (_____)_____ Fax Number (_____)_____