Franklin Medical GROUP, PC
An affiliate of Saint Mary's Health System

FRANKLIN MEDICAL GROUP, PC. NEW PATIENT INTAKE FORM

Last Name: _____ First Name: _____ DOB:_____ Age: _____

Date of Service: _____Present Occupation: _____

Marital Status: _____ Married _____ Divorced _____ Single _____ Widowed _____ Partnered _____

List household Members (name/age):
_____

List any Allergies to medicines, foods, insects, etc. with reaction: _____
_____

Lifestyle Review:
Please list approximate date of your last:
Dental exam: _____ Eye exam: _____ Any problems with hearing? _____
Are you on any special kind of diet? _____ If so, what kind? _____
Do you feel you eat a healthy diet? _____
Do you have any weight concerns? _____
Do you exercise? _____ How often? _____ What type? _____
Do you use tobacco products now or did you smoke in the past _____ Yes _____ No
If yes, what type: _____
How many / day _____? How many years _____? Age stopped _____?
About how much alcohol do you have on an average day? _____ or week? _____
Do you sometimes use street drugs (cocaine, marijuana, heroin, etc)? _____

Reproductive Health and Cancer Screening:

Men:
Are you sexually active? _____
How many partners in the past 5 years? _____
Men, women, or both? _____
Do you use birth control / contraception? _____
If yes, what type? _____
Do you have problems with sex or intercourse? _____
When was your last prostate screening?
PSA: _____ Exam: _____
Do you examine your testicles for lumps? _____
Date of last colonoscopy: _____

Women:
When was your last menstrual period? _____
Do you have any problems with periods? _____
Are you sexually active?_____
How many partners in the past 5 years? _____
Men, women, or both? _____
Do you use birth control / Contraception? _____
If yes, what type? _____
Number of pregnancies: _____
Number of births: _____
Date of last pap smear: _____
Date of last mammogram: _____
Do you check your breast for lumps? _____
Date of last colonoscopy: _____
Date of last bone density test: _____

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Risk Screening:

Do you always wear seatbelts in a car?	___ Yes___ No
Do you wear helmets when appropriate?	___ Yes ___ No
Do you wear sunscreen when appropriate?	___ Yes ___ No
Do you have working smoke and carbon monoxide detectors?	___ Yes ___ No
Do you have any unsecured firearms in your home?	___ Yes ___ No
Do you have any history of abuse or violence in your home?	___ Yes ___ No
Do you have problems with stress or anger management?	___ Yes ___ No
Have you had driving violations?	___ Yes ___ No
Do you have concerns about your memory?	___ Yes ___ No
Do you have any work or travel exposures or risks?	___ Yes ___ No

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IF YOU HAVE HAD A PHYSICIAL OR PRVENTATIVE EXAM WITH FRANKLIN MEDICAL GROUP, PC IN THE PAST, PLEASE ONLY RECORD ANY UPDATES OR CHANGES TO YOUR MEDICAL HISATORY IN THIS SECTION.

Immunizations

Date of last tetanus shot? _____Has it been more than 10 years? ___ Yes ___ No
If you're over 65, have you had the pneumonia shot (pneumovax)? ___ Yes ___ No
Do you get annual "Flu" (Influenza) vaccine? ___ Yes ___ No
Have you been exposed to Tuberculosis or had a positive TB test in the past? ___ Yes ___ No
Have you ever had chicken pox or shingles? ___ Yes ___ No
Have you had the Hepatitis B Vaccine? ___ Yes ___ No
Have you had the HPV (Gardasil) Vaccine? ___ Yes ___ No
If you're over 60, have you had the shingles vaccine? ___ Yes ___ No

Medical History:

CURRENT MEDICINES: **List all medications–include hormones, birth control pills, eye drops, vitamins, inhalers, creams, nasal sprays, supplements, and over the counter medicines. ☐ Check here if none.**

Name of Medication	Dose	Times Per Day	Name of Medication	Dose	Times Per Day

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Medical Conditions – Check all that apply now or in the past:

☐ Alcohol or drug problem	☐ Ear Problems	☐ Radiation Treatment
☐ Allergies / Hay Fever	☐ Gallbladder Problem	☐ Seizures/Epilepsy
☐ Anemia	☐ Headaches / Numbness	☐ Sexually Transmitted Disease
☐ Arthritis / Gout	☐ Heart Trouble/Angina/Heart Murmur	☐ Sleep Apnea/Sleep Problems
☐ Blood Clots / Phlebitis	☐ Hepatitis	☐ Skin Cancer/Rashes
☐ Cancer / Tumor	☐ High Cholesterol	☐ Stomach or Duodenal Ulcer/Heartburn
☐ Colon / Bowel Problem	☐ High Blood Pressure	☐ Stroke
☐ Depression / Anxiety	☐ Kidney Problems/Kidney Stones	☐ Thyroid
☐ Diabetes	☐ Liver Disease	☐ Urinary/Prostate/Sexual Problems
☐ Dizziness	☐ Lung Problems/Asthma	
☐ Abnormal Mammogram or Pap	☐ Lyme Disease	

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List any specialists you see on a regular basis:

LIST ALL HOSPITALIZATIONS, OPERATIONS, (INCLUDING CHILDHOOD), SERIOUS INJURIES, AND ILLNESSES SINCE YOUR LAST PHYSICAL EXAM AT FRANKLIN MEDICAL GROUP, PC

	YEAR		**YEAR**

FAMILY HISTORY:

If your Mother (m), Father (f), Sister (s), Brother (b), or Children (c) have any Please list which relative has had the medical problem

□ I don't know my family medical history □ I am adopted

□ Alcohol/Drug Problem	Family Member	□ Suicide	Family Member
□ Brest Cancer		□ Osteoporosis	
□ Colon Cancer/Polyps		□ Prostate Cancer	
□ Diabetes		□ Sickle Cell Anemia	
□ Heart Problem		□ Skin Cancer	
□ High Blood Pressure		□ Thyroid Problem	
□ High Cholesterol		□ Other Cancer	
□ Mental Illness/Depression		□ Other	
□ Other			

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