



Meeker Family Health Center

Phone: (970) 878.4014 – Fax: (970) 878.0019

100 PMC Drive, Meeker, CO 81641

Eastern Rio Blanco County Health Service District

Patient Intake and History Form

Name: _____

Date of Birth: _____

Occupation: _____

Employer: _____

Marital Status: Single Partner/Married Divorced Widowed Other: _____

Spouse/partner's name: _____

Who lives at home with you? _____

Number of children/ages: _____

Years of education/highest degree: _____

GENERAL MEDICAL HISTORY

	None	Self	Mother	Father	Sibling	Your Child	Grandparent	Aunt/Uncle
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you smoke/use tobacco No Yes How long? _____ How many per day _____

Do you drink alcohol? No Yes How many drinks per week? _____

Do you use recreational/illegal drugs? No Yes What and how long? _____

Allergy History:

List of known allergies (including medication allergies) and reaction to allergen. Or check one of the boxes:

No Known Allergies (NKA)

No Known Drug Allergies (NKDA)

What was the month and year of your last physical exam? _____

What was the month and year of your last:

Colonoscopy: _____
Never/Normal/Abnormal

Mammogram: _____
Never/Normal/Abnormal

Pneumonia Shot: _____
Pevnar 23 _____

Bone Density Study: _____
Never/Normal/Abnormal

Pap Smear: _____
Never/Normal/Abnormal

Tetanus Shot: _____

Zostavax (Shingles) Vaccine: _____

Have you had any surgery? List what surgeries you have had and the year you had it:

Medication History:

What medications do you take? Please include vitamins and supplements.

Name of Medication

Dose, # of times/day

What is it for?

Preferred Pharmacy: _____

Do you use a mail order pharmacy? _____

Preferred Mail Order Pharmacy _____

Please be sure we have your pharmacy provider information and a copy of your prescription drug card.

Do you currently follow up with any other Provider/Specialist? Please indicate name.

Cardiology _____

Neurology _____

Urology _____

Endocrinology _____

Nephrology _____

Optometry _____

Orthopedics _____

ENT _____

Therapy _____

Mental Health _____

Infection Disease _____

Gynecology _____

Pulmonologist_____

Oncology_____

Hepatology_____