PONTE VEDRA
CONCIERGE MEDICINE

Medical Intake Form

Past Medical History

Have you ever had any of the following? (Check boxes that apply):

- o Allergies
- o Anxiety
- o Arthritis(Rheumatoid/ Osteo)
- o Artificial heart valve or joints _____
- o Back problems
- o Bleeding abnormality
- o Blood disease
- o Cancer (type) _____
- o Cataracts
- o Chronic Diarrhea (Crohns, Ulcerative Colitis/Irritable Bowel/Other)
- o Circulatory Problems
- o COPD
- o Dementia
- o Diabetes
- o Depression
- o Epilepsy
- o Esophogeal Reflux Disease
- o Headaches (migraine/tension)
- o Heart murmur
- o Heart disease
- o Hemophilia
- o High Blood Pressure
- o High Cholesterol
- o HIV/AIDS
- o Liver disease
- o Pacemaker
- o Prostate Enlargement
- o Stroke
- o Sinus Problems
- o Thyroid Disease(Hypo/Hyper/ Nodule)
- o Ulcers
- o Other:_____

Medications

☐ None

List:

_____ _____

_____ _____

_____ _____

_____ _____

Allergies

☐ None ☐ _____

Surgery History

☐ None ☐ _____

Family History

☐ None

Father: _____

Mother: _____

Siblings:_____

Other:_____

Social History

Tobacco: (Check boxes that apply):

- Never
- Former smoker
  Year quit: _____
  Years smoking: _____
  Packs per day: _____
- Currently smoking
  Packs per day: _____
  Years smoking: _____
- Smokeless tobacco
- Vaping

Alcohol (circle): None Occasional 2-5 days per week >5 days per week

If you drink, how many drinks per day? _____

Any illicit drug use: ☐ None ☐ _____

Marital status (circle):

Married Single Divorced Widow Domestic partner

Sexual orientation (circle): Heterosexual Homosexual Bisexual

Advanced Directives: Yes No

Specialists

☐ None

List:

_____ _____

_____ _____

_____ _____

_____ _____

Patient Name: _____ DOB: _____

Signature:_____ Date: _____