Blue Stone
HEALTH & WELLNESS

Chart #: _____

New Patient Intake

_____ _____ _____

Patient Name *Date* *Date of Birth*

_____

Preferred Pharmacy & Secondary Pharmacy

Allergies:

Do you have any known drug allergies? ❒ Yes ❒ No

If yes, please list allergies and reactions:

Allergy: Reaction:

_____ _____

_____ _____

Medications:

Please list all current medications and doses that you are taking: ❒ No current medications

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

I have more medications to list. Please list any additional medications on reverse side of this form.

❒ Yes ❒ No

Vaccines:

Please list all vaccines you have received outside our practice: ❒ No vaccines

_____ _____

_____ _____

_____ _____

_____ _____

Medical Problems:

Please list all known current medical problems: ❒ No medical problems

_____ _____

_____ _____

_____ _____

Family History:

Please list any family member who has a known serious medical condition/illness:

Family relation:	Medical condition:	Onset Age:	Living?	Date of Death:
_____	_____	_____	❒ Yes ❒ No	_____
_____	_____	_____	❒ Yes ❒ No	_____
_____	_____	_____	❒ Yes ❒ No	_____

❒ First-degree relatives have no current problems or disabilities

❒ First-degree relatives' medical conditions are unknown

Social History:

Marital/Relationship Status: _____

Occupation: _____ ❒ Not currently employed

Religious Preference (Optional): _____

Sexually Active: ❒ Yes ❒ No ❒ N/A

Are you currently pregnant? ❒ Yes ❒ No ❒ N/A

Are you planning or trying to get pregnant? ❒ Yes ❒ No ❒ N/A

Public Health and Travel:

Have you traveled to a location with risk of COVID-19? ❒ Yes ❒ No If yes, where? _____

Were you symptomatic for COVID-19 within the last 14 days? ❒ Yes ❒ No

If yes, have you been in contact with people within the last 14 days? ❒ Yes ❒ No

Substance Use and Abuse:

Do or have you smoked tobacco? ❒ Yes ❒ No

Smoking Status: ❒ Never Smoker ❒ Former Smoker - Quit date: _____/_____/_____

❒ Current Every Day Smoker ❒ Current Someday Smoker

Tobacco Years of Use: _____

Have you used any other forms of tobacco or nicotine? ❒ Yes ❒ No

What was the date of the most recent tobacco screening? _____/_____/_____

Have you been provided with tobacco cessation counseling? ❒ Yes ❒ No

Alcohol Intake: ❒ None ❒ Occasional ❒ Moderate ❒ Heavy

How many days in the past year have you had heavy drinking consumption? (4+ female, 5+ male) _____

Any illicit drugs?: ❒ Yes ❒ No If yes, please specify: _____
Date of last colonoscopy: _____ OR ❒ Under the age of 50 ❒ Refused at this time
Date of last tetanus shot: _____
Would you like an influenza vaccine? ❒ Yes ❒ No ❒ Already had one this year - Date: _____
Would you like a pneumonia vaccine? ❒ Yes ❒ No ❒ Already had one this year - Date:
_____
When was your last lipid panel? ❒ Recent - Date: _____ ❒ Not Recent (Discuss with provider)

Do you have an Advanced Directive? ❒ Yes ❒ No (If yes, please provide a copy for our records)
If no Advanced Directive, would you like more information on this? ❒ Yes ❒ No ❒ Not at this time

Surgical History:
Please list past surgeries and dates: ❒ None

Procedure:	Date:
_____	_____
_____	_____

Past Medical History:

Anxiety disorder	❒ Yes ❒ No	Diabetes	❒ Yes ❒ No
Cancer	❒ Yes ❒ No	Heart Disease	❒ Yes ❒ No
Depression	❒ Yes ❒ No	Osteoporosis	❒ Yes ❒ No

Gynecological History: (Females only)
Date of last mammogram: _____
If mammogram is not current, are you interested in your provider ordering one? ❒ Yes ❒ No
Date of last PAP Smear: _____
Was PAP abnormal? ❒ Yes ❒ No
Have you had a hysterectomy? ❒ Yes ❒ No If yes, Full or Partial? _____
Have you ever been tested for Chlamydia? ❒ Yes ❒ No
Are you interested in being tested for any STDs? ❒ Yes ❒ No ❒ Unsure
If you have been tested for STDs or if you are unsure, please discuss with your provider.

TB Risk Assessment:
Date of last TB screening:_____ ❒ Positive ❒ Negative
If positive TB screen, date of last chest x-ray:_____ Result: ❒ Positive ❒ Negative
Have you recently traveled outside of the country? ❒ Yes ❒ No
If yes, when and where? _____
Do you have one or more signs or symptoms of TB? (Prolonged cough, coughing up blood, fever, night sweats, weight loss, excessive fatigue) ❒ Yes ❒ No
Have you had close contact with someone with TB? ❒ Yes ❒ No
Were you born outside of the country? ❒ Yes ❒ No If yes, please specify country: _____