WELLSPRING
FAMILY PRACTICE

Name: _____ Date of Birth: _____ Date: _____

Previous Doctor: _____

Patient Health Intake Questionnaire: This is one of the most important documents you will create for your medical providers. We will use the information you put on this form to create and complete your Clinical Summary. Please be as complete and accurate as possible. You may need to collect information from other sources to complete this form, such as your prescriptions immunization record and past medical records.

Allergies/Sensitivities:

Substance/Medication:	Reaction:	Onset Date:

Medications/Supplements:

Medication/Supplement:	Dose:	Route:	Frequency:	Reason:

Habits/Substance Use:

Substance-Type: (circle which one/s)	Amount:	Frequency:	Age Started	Age Quit:
Tobacco: cigarette, pipe, cigar, chew, e-cig				
Alcohol: beer, wine, hard alcohol				
Substance: marijuana, cocaine, meth, heroin, IV drugs				
Substance: benzodiazepine, opiates, other				
Activity: gambling, computers, television, games				

Past Medical History:

Disease Name:	First Diagnosed:	Treatment/Notes:

Past Surgical History:

Procedure Name:	Surgeon:	Date:	Reason for Procedure:

Family Medical History:

Disease Name:	Relative:	Age diagnosed:	Treatment/Outcome:

Social History:

Marital Status: Status/Spouse Name/Date	
Children: Sex/Age	
Education: Level/Degree	
Occupation: Type/Name of Employer	
Diet: Type/Limitations	
Code Status: Full Code/Life Support/Advance Directive	
Spiritual Belief System:	

Immunization History (Please bring immunization record):

Immunization:	**Last Booster/Shot Date:**	**What Facility:**

Reproductive History (For Women Only):

Age of 1st Menstruation: _____

Cycle Interval: _____ (# of days- 1st day of period to 1st day of next period)

Menses Duration: _____ (# of days) Flow: Light Medium Heavy (circle one)

Last Menstruation date: _____ Sexually Active: Yes No (circle one)

Method of Birth Control: _____ Monogamous: Yes No (circle one)

Hormone Replacement Therapy: Yes No (circle one)

Pregnancy: _____ (# of times) Miscarried: _____ (# of times)

Delivered: _____ (# of times) Aborted: _____ (# of times)

Premature: _____ (# of times)