NORWOOD Clinic

Gardendale Primary Care
313 Fieldstown Road ● Suite 103 ● Gardendale, AL 35071
Phone: (205)631-0055 ● Fax: (205)250-6439

New Patient Intake Form

Please complete the below information, to the best of your knowledge, and bring this form to your appointment.

NAME: ______________________________ **BIRTHDATE** ____________
ADDRESS: ______________________________
PHONE: *HOME* (____) __________ *WORK*: (____) __________ *CELL*: (____) __________
EMAIL ADDRESS: ______________________________
Would you like to be registered for the patient portal? □ Yes □ No
LOCAL PHARMACY
NAME/ADDRESS: ______________________________
PHARMACY PHONE # (____) __________ FAX# (____) __________
MAIL ORDER PHARMACY
NAME/CITY/STATE: ______________________________
PHARMACY PHONE # (____) __________ FAX# (____) __________

PLEASE CIRCLE ANY ILLINESSES YOU HAVE HAD:

Anxiety	Gonorrhea	Jaundice	Osteoporosis
Asthma	Gout	Kidney Disease	Rheumatic Fever
Bleeding Tendency	Heart Disease	Kidney Stones	Rheumatoid Arthritis
High Cholesterol	Heart Failure	Liver Disease	Seizures
Degenerative Arthritis	Hepatitis	Lung Disease	Syphilis
Depression	High Blood Pressure	Migraine Headache	Tuberculosis
Glaucoma	HIV/AIDS	Neuropathy	Vein Trouble

DIABETES (if yes, how long & **TYPE**) __________ CANCER (if yes, where) __________
OTHER ILLINESSES: ______________________________

PREVIOUS SURGERY/INJURIES (and date): ______________________________

DRUG ALLERGIES (also list reactions): □ None ______________________________

FAMILY HISTORY:
Father: Alive? Y or N Illnesses: __________ Age at death_____ Cause__________
Mother: Alive? Y or N Illnesses: __________ Age at death_____ Cause__________
Number of Siblings/Health Issues: ______________________________
Number of Children/Health Issues: ______________________________
Other Relatives Health Issues: ______________________________

SOCIAL HISTORY: Single, Married, Divorced, Widowed, Living with: __________
Smoking: □ No □ Yes, Packs a day____, How long ____ Circle Type: (pipe, cigar, cigarettes, chew)
Recently quit _____, Wants to quit_____
Alcohol: □ No □ Yes, Drinks/day average__________ Circle Type: (beer, wine, liquor)
Substance abuse: □ Y or □ N; List type of drug(s) used: ______________________________

Occupation: ______________________________
Caffeine: □ Y or □ N Drinks/day average__________ Circle Type: (tea, coffee, sodas, medicine, foods)
Hobbies: ______________________________
Diet: □ Y or □ N If yes, Circle Method of Diet: Low Carb, Low Calorie, Low Fat, Vegetarian, Other: __________
Exercise: □ Y or □ N Frequency _______ Duration _______ Type_ ______________________________

NORWOODClinic

Gardendale Primary Care
313 Fieldstown Road ● Suite 103 ● Gardendale, AL 35071
Phone: (205)631-0055 ● Fax: (205)250-6439

MEDICATIONS: □ See Below □ List Attached

NAME/DOSE/HOW IT'S TAKEN	NAME/DOSE/HOW IT'S TAKEN
1. ______________________________	6. ______________________________
2. ______________________________	7. ______________________________
3. ______________________________	8. ______________________________
4. ______________________________	9. ______________________________
5. ______________________________	10. ______________________________

HEALTH MAINTENANCE: (enter date of your last exam/study)
Assisted Device: (Please circle one) None, Walker, Power Scooter, Manual Wheelchair, Power Wheelchair

Bone Density: Date______________ Findings:_____________________ Performed by___________________________

Colonoscopy: Date_______________ Findings: _____________________ Performed by__________________________

Eye Exam: Date__________________ Findings:_____________________ Performed by___________________________

Diabetic Foot Exam: Date__________ Findings:_____________________ Performed by___________________________

Mammogram: Date_______________ Findings:_____________________ Performed by__________________________

OBGYN Care: Date________________ Findings:_____________________ Performed by__________________________

PSA (men): Date__________________ Findings:_____________________ Performed by__________________________

Other Physicians seeing you currently: ____ ________________

____ ________________

HOSPITALIZATIONS THIS YEAR (list reason/date):____

IMMUNIZATIONS AND DATES:
Gardasil_________ Hepatitis B_________ Influenza_________ Pneumovax_________ Measles_________
Meningococcal_______ Rubella_________ Tetanus_________ Shingles_________

REVIEW OF SYSTEMS:

CONSTITUTIONAL:	□ fevers/chills, □ night-sweats, □ anorexia, □ weight loss
EYES:	□ Blurry vision
EARS, NOSE, MOUTH & THROAT:	□ decreased hearing, □ runny nose, □ mouth sores, □ sore throat
CARDIOVASCULAR:	□ chest pain, □ palpitations, □ decreased exercise tolerance
RESPIRATORY:	□ cough, □ shortness of breath
GASTROINTESTINAL:	□ nausea/vomiting, □ difficulty swallowing, □ heartburn, □ diarrhea
	□ Constipation, □ blood in stool, □ hemorrhoid problems, □ abdominal pain
MUSCULOSKELETAL:	□ joint pain/swelling, □ weakness
DERMATOLOGIC:	□ rashes, □ suspicious skin lesions

Patient Signature: ____ Date: ____/____/____