Tampa Bay Family Physicians, Inc.

PATIENT INITIAL INTAKE QUESTIONNAIRE

Please show your answer by filling up the bubble signs e.g. ●

Name: _____ DOB: _____ Age: _____ Sex: ○ M ○ F

Who was your previous primary care provider? _____

CURRENT MEDICATIONS (Please list all of your medications):

Name of Medication	Dosage/Strength	Frequency/dosing Instructions
Example: Tylenol	*Example:500 mg*	*Example: 1 pill three times a day*
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Note: this information may be taken directly from the pharmacy label on prescription bottles

ALLERGIES (Are you allergic or sensitive to any medication?)

○ No Known Allergies ○ Medication Allergies ○ Environmental/Seasonal Allergies ○ Latex Allergy

Allergies	Reaction
Example: Dust, pollen, ibuprofen, amoxicillin etc.	*Example: skin rash, itchy eyes, hives, face bumps etc.*

PERSONAL MEDICAL HISTORY: Do you have now (current) or have you had (past) any of the following conditions?

○ NONE

Condition	Code	Current	Past	Comments
Alcohol/Drug abuse	305.00/305.90	○	○	
Allergy (Hay Fever)	477.9	○	○	
Anemia	285.9	○	○	
Angina		○	○	
Anxiety	300.00	○	○	
Arthritis (Rheumatoid)	714.0	○	○	
Arthritis (osteoarthritis)	715.90	○	○	
Asthma	493.90	○	○	
Bladder/Kidney Problems		○	○	
Blood Clot (leg)	453.40	○	○	

We would like to personally thank you for taking time to complete this form. Doing so provides us with the information necessary to make the most out of each and every healthcare visit together.

Condition	Code	Current	Past	Comments
Blood Clot (lung)	415.11	○	○	
Blood Transfusion	V58.2	○	○	
Breast Lump (benign)	611.72	○	○	
Cancer Breast	174.9	○	○	
Cancer Colon	153.9	○	○	
Cancer Other type		○	○	
Cancer Ovarian	183.0	○	○	
Cancer Prostate	185	○	○	
Cataracts	366.9	○	○	
Chicken Pox	052.9	○	○	
Colon Polyp	211.3	○	○	
Coronary Artery Disease	414.00	○	○	
Depression	311	○	○	
Diabetes (adult onset)	250.00	○	○	
Diabetes (childhood onset)	250.01	○	○	
Diverticulosis	562.10	○	○	
Emphysema (COPD)	492.8	○	○	
Fractures (broken bones)		○	○	Where?
Gallbladder Disease	574.20	○	○	
GERD/Acid Reflux/Heartburn	530.81	○	○	
Glaucoma	365.9	○	○	
Gout	274.9	○	○	
GYN conditions (Endometriosis)	617.9	○	○	
GYN conditions (Fibroids)	218.9	○	○	
GYN conditions (Other)		○	○	
Heart Attack / Myocardial Infarction (year)	410.90	○	○	
Hepatitis- Type A	070.1	○	○	
Hepatitis- Type B	070.30	○	○	
Hepatitis- Type C	070.51	○	○	
Hepatitis- Other	070.59	○	○	
High Blood Pressure/Hypertension	401.9	○	○	
High Cholesterol/ Hypercholesterolemia	272.0	○	○	
Hip Fracture	820.8	○	○	
Irritable Bowel Syndrome (IBS)	564.1	○	○	
Chronic Kidney Disease / Failure (CKD)	583/586	○	○	
Kidney Stones	592.0	○	○	
Liver Disease	273.9	○	○	
Migraine Headaches	346.90	○	○	
Osteoporosis	733.00	○	○	
Pneumonia	486	○	○	
Prostate (enlargement)	600.00	○	○	
Prostate (nodules)	600.10	○	○	
Seizure/Epilepsy	780.39	○	○	
Skin Condition (Eczema)	692.9	○	○	
Skin Condition (Psoriasis)	696.1	○	○	

We would like to personally thank you for taking time to complete this form. Doing so provides us with the information necessary to make the most out of each and every healthcare visit together.

Condition	Code	Current	Past	Comments
Skin Condition (Abnormal Moles)	238.2	○	○	
Sleep Apnea	780.57	○	○	
Stomach Ulcer	531.90	○	○	
Stroke	434.91	○	○	
Thyroid (Nodule)	241.0	○	○	
Thyroid High (Overactive)/ Hyperthyroidism	242.90	○	○	
Thyroid Low (Underactive)/ Hypothyroidism	244.9	○	○	
Other (list)		○	○	
Other (list)		○	○	

PAST SURGICAL HISTORY (Have you had any of the following surgical procedures?): ○ None.

Surgical Procedure	Yes	Year	Comments
Appendectomy (Appendix removal)	○		
Back Surgery (lumbar)	○		
Breast Surgery	○		
Colonoscopy	○		
Coronary Stent	○		
EGD (Stomach Endoscopy)	○		
Cataract	○		
Gallbladder Removal	○		
Heart Surgery (other than coronary bypass)	○		
Hip Replacement	○		
Hysterectomy (total, including ovaries)	○		
Hysterectomy (partial, ovaries left)	○		
Knee Replacement	○		
LEEP (Cervix Surgery)	○		
Neck Surgery	○		
Ovary Ligation(“Tubal”)	○		
Ovary Removal	○		
Tonsillectomy	○		
Vasectomy	○		
Other (list)	○		

PAST HOSPITALIZATIONS:

DATE	Reason

We would like to personally thank you for taking time to complete this form. Doing so provides us with the information necessary to make the most out of each and every healthcare visit together.

FAMILY HISTORY:

Adopted — ○ Yes ○ No (please Check) if yes and you do not know your family history skip this section and continue to next page.

Indicate which relative has had the following diseases (parents and siblings are most important)

Disease	Mother	Father	Sister(s)	Brother(s)	Other Relative	Comments
No significant history known	○	○	○	○	○	
Alcohol / Drug Abuse	○	○	○	○	○	
Alzheimers	○	○	○	○	○	
Asthma	○	○	○	○	○	
Autoimmune Disease	○	○	○	○	○	
Bleeding or Clotting Disorder	○	○	○	○	○	
Cancer Breast	○	○	○	○	○	
Cancer Colon	○	○	○	○	○	
Cancer Other Type	○	○	○	○	○	
Cancer Ovarian	○	○	○	○	○	
Cancer Prostate	○	○	○	○	○	
Colon Polyp	○	○	○	○	○	
Coronary Artery Disease (e.g. heart attack, angina)	○	○	○	○	○	
Depression / Suicide / Anxiety	○	○	○	○	○	
Diabetes (childhood onset)	○	○	○	○	○	
Diabetes (adult onset)	○	○	○	○	○	
Emphysema (COPD)	○	○	○	○	○	
Genetic Disorder (explain)	○	○	○	○	○	
Glaucoma	○	○	○	○	○	
Heart Disease (CHF)	○	○	○	○	○	
Heart Disease (Other)	○	○	○	○	○	
Hepatitis B or C	○	○	○	○	○	
High Blood Pressure-Hypertension	○	○	○	○	○	
High Cholesterol	○	○	○	○	○	
Hip Fracture	○	○	○	○	○	
Hypothyroidism/Thyroid Disease	○	○	○	○	○	
Kidney Disease	○	○	○	○	○	
Macular Degeneration	○	○	○	○	○	
Migraine Headaches	○	○	○	○	○	
Osteoporosis	○	○	○	○	○	
Other (list)	○	○	○	○	○	

We would like to personally thank you for taking time to complete this form. Doing so provides us with the information necessary to make the most out of each and every healthcare visit together.

SOCIAL HISTORY

Personal History

Marital Status ○ Single ○ Married ○ Divorced ○ Widowed ○ No Answer

Adults in household: _____

Children: ○ Yes ○ No Number of Children: _____ Ages if under 18 years: _____

Living Situation: ○ Live Alone ○ With Significant Other/Spouse ○ With Children/Family Members ○ Others

Occupation: _____

Hobbies/Interests: _____

Tobacco

Have you ever smoked? ○ Yes ○ No (if no or you never smoked, please go to alcohol use question now)

If yes, what do you (did you) smoke? _____

Are you still smoking? ○ Yes ○ No

If no: How many years ago did You quit? _____ For how many years did you smoke? _____ How many packs/day did you smoke? _____

If yes: How many years have you smoked? _____ How many packs/day do you smoke? _____ Have you ever tried to quit? _____

Alcohol

Do you drink alcohol? ○ Yes ○ No

If yes please specify: ○ Beer ○ Wine ○ Liquor

○ Daily ○ Almost Daily (4-6 times/week) ○ 1-3 times/week ○ Less than once time/week

Do you drink Caffeine? ○ Yes ○ No if yes, how many cups per day? _____

Illicit Drugs

Do you use any drugs or prescription medications not prescribed to you? ○ Yes ○ No

If yes please specify type of drug and frequency of use - _____

Diet/Activity

How would you rate your diet? ○ Good ○ Fair ○ Poor

Are you on any special diet? ○ Yes ○ No

If yes, how would you describe your diet? _____

Do you exercise regularly? ○ Yes ○ No

If yes, please describe: _____

How Long (minutes)? _____ How often? _____

Sexual Activity

Sexually involved currently: ○ Yes ○ No

Sexual Partner(s) is/are/have been: ○ male ○ female

Birth Control method: ○ None needed ○ Condom ○ pill ○ diaphragm ○ vasectomy ○ Other_____

Safety

Do you use a bike helmet?	○ No bike	○ Yes	○ No
Do you use seatbelts consistently?		○ Yes	○ No
Does your home have working smoke detector?		○ Yes	○ No
If you have guns in your home, are they locked up?	○ N/A	○ Yes	○ No

We would like to personally thank you for taking time to complete this form. Doing so provides us with the information necessary to make the most out of each and every healthcare visit together.

Is violence at home a concern for you? ○ Yes ○ No
Have you completed an Advance Directive for health Care (ADHC)? ○ Yes ○ No
○ Living Will ○ Durable Power of Attorney ○ Health Care Proxy ○ Advanced Directives

HEALTH MAINTENANCE

Please provide the dates and results of the following immunizations, examinations, and tests to the best of your ability. If you have not had one of these services please indicate N/A (not applicable).

All Patients:

Last Complete Physical	Date: _____		By: _____	
Last Tetanus Booster	○ Within past 10 years		○ More than 10 years ago	○ Unknown
Last Eye Exam	Date: _____	○ Normal	○ Abnormal	○ Unknown
Last Hearing Exam	Date: _____	○ Normal	○ Abnormal	○ Unknown
Last Sigmoidoscopy/ Colonoscopy or stool test	Date: _____	○ Normal	○ Abnormal	○ Unknown
Last DEXA Bone Scan	Date: _____	○ Normal	○ Abnormal	○ Unknown
Last Pneumonia Vaccine	Date: _____	○ Normal	○ Abnormal	○ Unknown
Flu shot this season?	○ Yes	○ No		

Only Women:

Last Pap Smear	Date: _____	○ Normal	○ Abnormal	○ Unknown
Last Mammogram	Date: _____	○ Normal	○ Abnormal	○ Unknown

Only Men:

Last Prostate Specific Antigen-PSA	Date: _____	○ Normal	○ Abnormal	○ Unknown
Last Prostate Exam	Date: _____	○ Normal	○ Abnormal	○ Unknown

We would like to personally thank you for taking time to complete this form. Doing so provides us with the information necessary to make the most out of each and every healthcare visit together.