NABORS FAMILY MEDICINE

NEW PATIENT INTAKE FORM

Please complete before your appointment. Mark "N/A" when not applicable.

PATIENT INFORMATION

Full Name: _____ **DOB:** _____ **AGE:** _____

Address: _____

City: _____ **State:** _____ **ZIP:** _____

Phone: _____ **ALTERNATIVE PHONE:** _____ **Email:** _____

Preferred Contact: ☐ Phone ☐ Text ☐ Email ☐ Portal **Preferred Language:** _____

EMERGENCY CONTACT

Name: _____ **Relationship:** _____

Phone: _____

INSURANCE

Primary Insurance: _____

Member ID: _____ **Group #:** _____

Subscriber Name: _____ **DOB:** _____

Relationship to Subscriber: _____

Secondary Insurance (if applicable): _____

Member ID: _____ **Group #:** _____

PREVIOUS PRIMARY CARE

Previous PCP/Practice: _____

Phone: _____ **Last Visit:** _____ **Date of Last Physical:** _____

Recent Bloodwork/Labs: ☐ Yes ☐ No

If yes, when and where: _____

Request records: ☐ Yes ☐ No

MEDICAL HISTORY

Check all that apply:

☐ Hypertension ☐ High Cholesterol ☐ Heart Disease ☐ Stroke/TIA

☐ Diabetes ☐ Thyroid Disease ☐ Asthma/COPD ☐ Sleep Apnea

☐ Kidney Disease ☐ Liver Disease ☐ GI Disease ☐ Arthritis/Osteoporosis

☐ Cancer ☐ Blood Clot/DVT/PE ☐ Seizures ☐ Migraines

☐ Depression ☐ Anxiety ☐ Other Mental Health Condition

☐ Other: _____

SURGICAL HISTORY

Surgery/Procedure	Date/Year
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES

Medication/Food/Other: _____ **Reaction:** _____

Medication/Food/Other: _____ **Reaction:** _____

Medication/Food/Other: _____ **Reaction:** _____

☐ No Known Drug Allergies

CURRENT MEDICATIONS

Include prescriptions, OTC medications, vitamins, and supplements.

Medication	Dose	Frequency	Refill Needed?
_____	_____	_____	☐ Y ☐ N
_____	_____	_____	☐ Y ☐ N
_____	_____	_____	☐ Y ☐ N
_____	_____	_____	☐ Y ☐ N

_____ _____ _____ ☐Y ☐N

Preferred Pharmacy: _____

Pharmacy Phone: _____

FAMILY HISTORY

Condition	Mother	Father	Sibling	Child
Heart Disease	☐	☐	☐	☐
High BP	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐
Prostate Cancer	☐	☐	☐	☐
Mental Health	☐	☐	☐	☐
Other (Explain)	☐	☐	☐	☐

Additional family history:

SOCIAL HISTORY

Tobacco/Nicotine: ☐ Never ☐ Former ☐ Current

Type/Amount: _____ **Quit Date:** _____

Alcohol: ☐ None ☐ Occasional ☐ Weekly ☐ Daily **Typical drinks/week:** _____

Recreational/Other Substance Use: ☐ None ☐ Current ☐ Former **Type/Frequency:**
_____

Occupation: _____

Exercise: _____

Living situation: _____

Do you feel safe at home? ☐ Yes ☐ No ☐ Prefer to discuss privately

HEALTH MAINTENANCE

Most recent date or year:

Flu Vaccine: _____ **COVID Vaccine:** _____ **Tdap/Td:** _____ **Shingles:** _____

Pneumococcal: _____ **RSV:** _____ **Other vaccines:** _____

Last Eye Exam: _____ **Last Dental Exam:** _____ **Last Colonoscopy:** _____

Last Prostate Exam: _____ **Last Mammogram:** _____ **Last Pap Smear:** _____

REPRODUCTIVE & MENSTRUAL HISTORY

Number of Pregnancies: _____ **Live Births:** _____

Miscarriages: _____ **Abortions:** _____ **Living Children:** _____

Age at First Period: _____

Last Menstrual Period: _____

Typical Cycle: _____ days

Periods: ☐ Regular ☐ Irregular ☐ Menopausal/Postmenopausal

Menstrual concerns: ☐ None ☐ Heavy Bleeding ☐ Pain ☐ Irregularity

☐ Other: _____

Pregnancy/delivery complications:

SEXUAL HEALTH & CONTRACEPTION

Currently sexually active: ☐ Yes ☐ No ☐ Prefer not to answer

Current contraception:

☐ None ☐ Condoms ☐ Pills ☐ IUD ☐ Implant ☐ Injection

☐ Patch ☐ Ring ☐ Sterilization ☐ Other: _____

Would you like to discuss contraception/family planning? ☐ Yes ☐ No

Would you like STI screening? ☐ Yes ☐ No

MENTAL HEALTH

Over the past two weeks, have you felt down, depressed, or hopeless? ☐ No ☐ Yes

Over the past two weeks, have you felt little interest or pleasure in doing things? ☐ No ☐ Yes

Would you like to discuss your mood, stress, anxiety, sleep, or emotional health today?

☐ No ☐ Yes

Current concerns:

HEALTHCARE TEAM

Specialty	Provider/Practice	Phone
Cardiology	_____	_____
Dermatology	_____	_____
Gastroenterology	_____	_____
Gynecology/Urology	_____	_____
Eye Care	_____	_____
Mental Health	_____	_____
Other	_____	_____

ADVANCE DIRECTIVES

Advance Directive/Living Will: ☐ Yes ☐ No ☐ Unsure

Healthcare Proxy/Power of Attorney: ☐ Yes ☐ No ☐ Unsure

Healthcare Proxy Name: _____

Relationship: _____ **Phone:** _____

Copy available for chart: ☐ Yes ☐ No

TODAY'S VISIT

What are your top health concerns or goals today?

1.
2.
3.

Anything else your healthcare team should know?

PATIENT ATTESTATION

I confirm that the information provided is accurate to the best of my knowledge and will notify my healthcare team of significant changes.

Patient/Guardian Signature: _____

Date: _____