SANTA MONICA FAMILY PHYSICIANS
ADULT PATIENT INTAKE QUESTIONNAIRE
TODAY'S DATE: ____________________

PATIENT NAME: ________________________
DATE OF BIRTH: ________________________

Your primary language (if not Engish): ______________________________

Mailing address: ____

Phone #: ____
(Primary/preferred) (alternate number)

Emergency contact: ____
(name) (relationship) (phone)

Your Occupation: _________________________ Employer: ______________________________

YOUR MEDICAL HISTORY:

ALLERGIES: No / Yes – *if yes, please list all medication allergies and the type of reaction you had:*
____
____
____
____

MEDICATIONS: *List with doses. Include contraceptives, vitamins, supplements, etc. Attach list if needed.*
____
____
____
____
____
____
____
____

HABITS/LIFESTYLE:

Do you smoke? (circle one) NO / Current Smoker / Past smoker
If YES, how much?: _________________ For how long?: ____________________

How often do you drink alcoholic beverages? (circle one):
WEEKLY DAILY OTHER: ___________

How often do you exercise now? (circle one): WEEKLY DAILY OTHER: __________

Are you sexually active? NO / YES **Current birth control method**:
____

PATIENT NAME: __________________
DOB: ____________________________

YOUR MEDICAL CONDITIONS (circle all that apply):

Allergies
Anemia
Anxiety
Arthritis
Asthma
Cancer
Clotting disorder
Congestive heart failure
Depression
Diabetes
Emphysema/COPD
Gastroesophageal reflux (GERD)

Glaucoma
Heart murmur
Heart disease
HIV/AIDS
High cholesterol
Hypertension/high blood pressure
Kidney disease
Osteoporosis
Seizures
Sickle cell anemia
Thyroid disease

Details/Other:____
____

YOUR SURGICAL HISTORY (circle all that apply):

Appendectomy
Bladder surgery
Blood transfusion
Brain surgery
Breast surgery
CABG or Coronary Stent
Cholecystectomy/Gallbladder
Colon surgery
C-section
Eye surgery
Fracture surgery
Hernia repair

Hysterectomy
Joint surgery
Lung surgery
Prostate surgery
Spine surgery
Thyroid surgery
Tonsillectomy
Valve replacement
Vasectomy
Vascular surgery
Weight reduction surgery

Other:____
____

FAMILY HISTORY

Do you have a relative with any of the following? (Circle ALL that apply)
If yes, who (parent, sibling, etc)?

Breast cancer
Colon cancer
Heart disease
Ovarian cancer
Prostate cancer
Other:____
____

PATIENT NAME: ___________________
DOB: _____________________________

PREVENTIVE HEALTH: *Please indicate the date(s) of your last:*

Tetanus shot (Td or Tdap) within the last **10 years**: ______________________
Adult MMR (measles/mumps/rubella) vaccine: _________________________
chicken pox or Varicella vaccine: __________________________________
(for 50 and older): SHINGRIX vaccine: ________________________________
(for 65 and older): Pneumonia vaccine: ________________________________
colonoscopy: Date & Location: ___________________________________
Bone density test (DEXA): ___________________________________

GYNECOLOGIC QUESTIONS *(female patients, please answer these if applicable):*

Age when you started having periods: __________________________________
When was the first day of your last menstrual period?: ___________________
Usual menstrual flow lasts: ________ # of days Occurs every __________ days
Date (approx.) of:
last pap:____
last mammogram: ____________________________________