FIDALGO ISLAND WALK-IN CLINIC

PATIENT INTAKE FORM

Welcome to our clinic !

All information is strictly confidential.

Today's Date______/______/______

Name:____ Date of Birth:_____/______/______

Reason for visit: ____

Primary care provider : ____

Medication Allergies : ____

Past Medical History : *Please list all important medical problems.*

____

Surgeries : *Please list all surgeries.*

____

Medications : *Please list ALL medications you are currently taking, including supplements.*

____

Pharmacies: : *Please list the Pharmacies you use*____

Health Habits : *Please check which substances you use and describe how much you use.*

		Amount	
☐	Caffeine	________________	Daily / Weekly
☐	Cigarettes	________________	Daily / Weekly
☐	Chew Tobacco	__________	Daily / Weekly
☐	Alcohol	________________	Daily / Weekly
☐	Drugs	________________	Daily / Weekly
☐	Other	________________	Daily / Weekly

Immunizations::

Date Received

Last Tetanus: ____________/______/______

Last Flu: _______________/_______/______

Other needed: ___________________________

Women Only :

Last Menstrual Period _____________________________Contraceptive Method _________________________

Last Annual Exam _____________________________History of Irregular PAP smear ☐ Yes ☐ No

Do you think you migtht be pregnant**?** ☐ Yes ☐ No ☐ Maybe

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