COVENANT
FAMILY
MEDICINE
A Northside Network Provider

2069 Teron Trace
Suite 100
Dacula, GA 30019
Office 678-730-1620
Fax 678-730-0858

Date: _____

Patient Name: _____ **Date of Birth** _____ /_____ /_____

Gender: _____

REASON FOR VISIT:

_____

_____

Local Pharmacy

Name:_____

Address: _____

_____

Phone: _____

Fax: _____

Mail-Order Pharmacy

Name:_____

Address: _____

_____

Phone: _____

Fax: _____

MEDICATIONS SUPPLEMENTS AND VITAMINS: (Please list the name, dosage and frequency of current medications)

	MEDICATION	DOSAGE	FREQUENCY (HOW OFTEN)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

☐ **Patient brought in Medication List** **Medication List Reviewed by** _____

Allergies: _____

_____

_____

PATIENT INTAKE FORM

Patient Name: _____ **Date of Birth** ___ /___ /_____

MEDICAL HISTORY: (Please check ✓all that apply and diagnosis date)

☐ High Blood Pressure _____ ☐ Arthritis _____ ☐ Thyroid Disease (please specify)_____
☐ High Cholesterol _____ ☐ Kidney Disease _____ ☐ Heart Disease (please specify) _____
☐ Diabetes _____ ☐ Asthma _____ ☐ Cancer (please specify) _____
☐ Stroke _____ ☐ Osteoporosis _____ ☐ Clotting disorder (please specify) _____
☐ Anxiety _____ ☐ Depression _____ ☐ Acid Reflux _____
☐ Other: _____

SURGICAL HISTORY: (Please list any surgical procedures, hospitalizations and their dates)

FACILITY	REASON	DATE

SOCIAL HISTORY:

Do you currently smoke or chew tobacco? ☐ Yes ☐ No
If yes, how long have you smoked?_____
How much do you smoke per day? _____
Do you currently drink alcohol? ☐ Yes ☐ No
How much do you drink?_____
Do you feel like you need to cut back? _____
If you smoked previously, how long did you smoke, how much per day and when did you quit?

_____

Do you exercise regularly? ☐ Yes ☐ No If yes, how often and for how long do you exercise?_____
Have you used street drugs? ☐ Yes ☐ No If yes, what have you used? _____
Do you desire STD Screening? ☐ Yes ☐ No Do you consume caffeine? ☐ Yes ☐ No

FAMILY HISTORY: (Please list below blood relatives that have a history of the following:)

(☑) boxes that apply	Living	Deceased	Age / Age at Death	Stroke	Hypertension	Kidney Disease	Heart Disease	Diabetes	Cancer	Other (Please list)
Mother										
Father										
Siblings										
Grandmothers										
Grandfathers										
Children										

Have you ever had a blood transfusion? ☐ No ☐ Yes, Date: _____

PATIENT INTAKE FORM

Patient Name: _____ **Date of Birth** ___ /___ /_____

PLEASE FILL IN DATE OF YOUR LAST:

Colonoscopy		Pap Smear		Shingles shot	
Mammogram		Flu shot (Regular/High Dose)		Pneumonia shot Prevnar 13	
Bone Density		Tetanus shot		Pneumonia shot (Pneumovax 23) _____	
First day of last menstrual cycle:				How many doses?	

REVIEW OF SYSTEMS: (Please verify if you have had any of the following <u>within the last 30 days</u>) Please check ✓all that apply and explain

CONSTITUTIONAL
- ☐ Fever _____
- ☐ Weight Loss _____
- ☐ Difficulty Sleeping _____
- ☐ Fatigue _____
- ☐ Weight Gain _____
- ☐ Dehydration _____
- ☐ Headache _____

EYES
- ☐ Changes in Vision _____
- ☐ Far-Sightedness _____
- ☐ Near-Sightedness _____
- ☐ Total Vision Loss _____
- ☐ Eye Pain _____

EARS, NOSE, MOUTH, AND THROAT
- ☐ Loss of Hearing _____
- ☐ Cold Symptoms _____
- ☐ Ringing in Ears _____
- ☐ Hoarseness _____
- ☐ Sneezing Spells _____
- ☐ X-Ray Exposure to Tonsils, Adenoids, Thymus, or Face _____

BREASTS
- ☐ Lumps _____
- ☐ Nipple Discharge _____
- ☐ Tenderness _____
- ☐ Abnormal Changes in Breast Size _____

RESPIRATORY
- ☐ Wheezing _____
- ☐ Dry Cough _____
- ☐ Shortness of Breath _____
- ☐ Productive Cough _____

CARDIOVASCULAR
- ☐ High Blood Pressure _____
- ☐ Heart Trouble _____
- ☐ Palpitations _____
- ☐ Edema (swelling) _____
- ☐ Chest Pain _____

GASTRONINTESTINAL
- ☐ Abdominal Pain _____
- ☐ Vomiting _____
- ☐ Nausea _____
- ☐ Blood in Stool _____
- ☐ Tarry or Black Stool _____
- ☐ Hemorrhoids _____
- ☐ Hernias _____
- ☐ Heartburn _____
- ☐ Diarrhea/Loose Stools _____
- ☐ Mucus in Stool _____
- ☐ Loss of Appetite _____
- ☐ Bloating _____
- ☐ Constipation _____
- ☐ Excessive Belching _____
- ☐ Changes in Bowel Habits _____

GENITOURINARY
- ☐ Difficulty Urinating _____
- ☐ Sexually Transmitted Infections _____
- ☐ Incontinence _____
- ☐ Kidney Trouble _____
- ☐ Irregular Periods _____
- ☐ Erectile Dysfunction _____

NEUROLOGIC
- ☐ Dizziness _____
- ☐ Fainting _____
- ☐ Muscular Weakness _____
- ☐ Tingling or Numbness _____
- ☐ Seizures _____
- ☐ Nervous Disorders _____

MUSCULOSKELETAL
- ☐ Joint Pain _____
- ☐ Joint Swelling _____
- ☐ Reddish Coloring at Joints _____
- ☐ Stiffness _____
- ☐ Muscle Pain
- ☐ Muscular Weakness _____
- ☐ Back Pain _____
- ☐ Arm Pain _____
- ☐ Leg Pain _____
- ☐ Leg Cramps _____
- ☐ Urge to Move Legs _____

ENDOCRINE
- ☐ Thyroid Disease _____
- ☐ Diabetes Mellitus _____

PSYCHIATRIC
- ☐ Depressive Symptoms _____
- ☐ Anxiety _____
- ☐ Psychosis _____
- ☐ Hallucinations _____

ALLERGIC-IMMUNOLOGIC
- ☐ Sinus Allergy Symptoms _____
- ☐ Allergic Dermatitis _____

Patient's Signature: _____ **Date:** _____

PATIENT INTAKE FORM