**Ade Medical Group**

**Wellness Intake Form**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you had any changes with medical history in the past year? Yes or No

If so, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you had any changes with surgical history in the past year? Yes or No

If so, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you see any new Specialists? If so, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Do you have any new allergies to food or drug? If so, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication List:**

Please list **all** prescription and non-prescription medications. This includes vitamins, herbal medicine, supplements, birth control pills, inhalers and over the counter medications.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication** | **Dosage** | **How often** | **Disease or Reason** | **Prescribed by** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
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|  |  |  |  |  |

Preferred Local Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mail order Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Family History:

|  |  |  |  |
| --- | --- | --- | --- |
| **Family Member** | **Age(s)** | **Living** | **Cause of Death** |
| Father |  |  |  |
| Mother |  |  |  |
| Brother(s) # |  |  |  |
| Sister(s) # |  |  |  |

**Diseases in the family:** *(check all that apply)*

|  |  |  |  |
| --- | --- | --- | --- |
| * Arthritis | * Cancer | * Depression/Anxiety | * High cholesterol |
| * Addiction problems | * Breast | * Diabetes | * Kidney disease |
| * Bleeding problems | * Colon | * Heart disease | * Liver disease |
|  | * Prostate | * High blood pressure | * Mental Illness |
|  | * Other |  |  |

# Social History:

Do you live: Alone ☐ with Spouse or Partner ☐ with Family ☐ Other ☐

Who do you rely on for support and help?

Do you smoke? ☐ Currently ☐ Past ☐ Never packs/day for years Date quit:

Do you use a vape pen? ☐ Currently ☐ Never Do you use an e-cigarette? ☐ Currently ☐ Never

If you do smoke, are you interested in quitting? ☐ YES ☐ NO

Other nicotine use ☐ YES ☐ NO

Exposure to second hand smoke? ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO ☐ Beer ☐ Wine ☐ Liquor How many drinks per week? How many caffeinated beverages per day? ☐ Coffee ☐ Tea ☐ Sodas ☐ Energy Supplements

Any recreational drug use? ☐ YES ☐ NO

Type:

Do you exercise regularly? ☐ YES ☐ NO If so how many times per week? Type of exercise: Do you feel safe in your home? ☐ YES ☐ NO

How many hours of sleep do you get per night? Do you wake feeling well rested? ☐ YES ☐ NO

Please sign below to indicate the above information is accurate to the best of your knowledge.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_