ADE MEDICAL GROUP

Patient Intake Form

Please answer the following questions:

Name: _____

Preferred name (what would you like to be called): _____

Address: _____

Date of Birth: _____ **Sex:** Male or Female

Phone: _____ **Preferred to way to be contacted:** PHONE or TEXT

E-mail address to have on file: _____

Marital Status:

MARRIED DIVORCED PARTNER SINGLE WIDOWED LEGALLY SEPARTED UNKNOWN

Race: _____ **Ethnicity:** Hispanic Non-Hispanic Decline to Specify

Primary Language: _____

Preferred Pharmacy: _____

_____ **Phone#:** _____

Are you a United States Veteran? YES or NO **If yes, which branch:** _____

Employment Status:

FULL-TIME PART-TIME RETIRED SELF-EMPLOYED NOT-EMPLOYED ACTIVE-DUTY STUDENT

Living Arrangements:

PERMANENT RESIDENT SEASON RESIDENT MIGRANT HOMELESS

****Do you have a Power of Attorney – Healthcare?** YES or NO

****Do you have a DNR (Do Not Resuscitate)?** YES or NO

****If you have answered yes to any of these options, we need these on file.**

You may drop them off at the front desk or:

You may fax any POA/DNR/DNI to: 309-762-5519

You may e-mail: Medicalrecords@amgqc.com

ADE MEDICAL GROUP

New Patient Medical History Form

Date:_____

Name:_____ **DOB:**_____ **SSN#:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Phone Number:_____ **E-mail address:**_____

PAST MEDICAL HISTORY *(check all that apply)*

- ☐ Acid Reflux
- ☐ Alcohol Problem
- ☐ Allergy Problems
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Bleeding Problems
- ☐ Blood Clots
- ☐ Cancer
- ☐ Cataracts
- ☐ Colitis/Chrohn's
- ☐ Chronic Pain
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Problem
- ☐ Esophagitis ulcers
- ☐ Fractures
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Gout
- ☐ Headaches
- ☐ Heart Disease
- ☐ Heart Valve Problems
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Irritable Bowel
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease/Hepatitis
- ☐ Lung Disease
- ☐ Migraines
- ☐ Mental Health
- ☐ MRSA
- ☐ Osteoporosis
- ☐ Recurrent Skin infections
- ☐ Recurrent UTI
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ TB
- ☐ Thyroid Disease

Other diseases not listed above:_____

Hospitalizations/Significant injuries:_____

SURGERY/PROCEDURE HISTORY *(check all that apply)*

- ☐ Appendix
- ☐ Bladder Suspension
- ☐ Colon/Rectal surgery
- ☐ Dental Surgery
- ☐ Eye Surgery
- ☐ Gallbladder
- ☐ Heart Surgery
- ☐ Heart Bypass
- ☐ Heart Valve Surgery
- ☐ Heart Angioplasty (balloon)
- ☐ Heart Stents
- ☐ Heart Pacemaker
- ☐ Hysterectomy
- ☐ Complete ☐ Partial
- ☐ Hernia
- ☐ Joint Replacement
- ☐ Kidney Surgery
- ☐ Organ Transplant
- ☐ Orthopedic Surgery
- ☐ Prostate Surgery
- ☐ Sinus Surgery
- ☐ Thyroid Surgery
- ☐ Tonsils and/ or Adenoids
- ☐ Tubal Ligation
- ☐ Vasectomy

Other surgery not listed above:_____

Previous reaction to anesthesia: *(explain)*_____

ADE MEDICAL GROUP

New Patient Medical History Form

Please list the names of other practitioners you have or are currently seeing:

_____ _____ _____

_____ _____ _____

MEDICATION LIST

MEDICATION	DOSAGE	HOW OFTEN	DISEASE/REASON	PRESCRIBED BY

ALLERGIES OR REACTIONS

MEDICATION/FOOD/ENVIRONEMENTAL	REACTION

Preferred Local Pharmacy

Name:_____ Phone Number:_____

Address:_____ City:_____ State:_____ Zip:_____

Mail order Pharmacy

Name:_____ Phone Number:_____

Address:_____ City:_____ State:_____ Zip:_____

ADE MEDICAL GROUP

New Patient Medical History Form

FAMILY HISTORY

FAMILY MEMBER	AGE	LIVING	CAUSE OF DEATH
Father			
Mother			
Brother(s) #			
Sister(s) #			

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

- ☐ Arthritis
- ☐ Addiction Problems
- ☐ Anxiety
- ☐ Bleeding Problems
- ☐ Cancer
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Prostate Caner
- ☐ Depression
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Illness

SOCIAL HISTORY

Do you live: ☐ Alone ☐ with a spouse or partner ☐ with family ☐ other

Who do you rely on for support and help?_____

Do you smoke? ☐ Currently: packs/day____ years_____ ☐ Past: Date quit:_____ ☐ Never

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 secondhand 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 ☐ Soda ☐ 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 up feeling well rested? ☐ YES ☐ NO

New Patient Medical History Form

PREVENTIVE CARE:

Date of last Colon and Rectal Screening/location/Provider:_____

Have you had a bone density (DEXA) exam? ☐YES ☐NO If yes, date and location?_____

Date and location of last eye exam:_____

Date and location of last dental exam:_____

IMMUNIZATIONS

IMMUNIZATION	DATE
Tetanus	
Influenza/Flu	
Pneumonia	
Whooping Cough	
Hepatitis A	
Hepatitis B	
Shingles	
HPV	

FEMALE PATIENTS ONLY

Date of last menstrual period:_____

Do you have a Gynecologist? ☐YES ☐NO If yes, Gynecologist name:_____

Date of last PAP test:_____ Date of last Mammogram:_____

Have you gone through menopause? ☐YES ☐NO

Menstrual problems: ☐Irregular ☐Heavy ☐Change in frequency

Number of Pregnancies:_____ Number of live births?_____ Current birth control method:_____

MALE PATIENTS ONLY

Date of last PSA test:_____ Date of last Rectal exam:_____

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

Patient Signature:_____ Date:_____

Annual Wellness Visit Pre-Visit Questionnaire

DEPRESSION SCREENING

Over the last 2 weeks, how often have you been bothered by the following problems?

1. Little interest or pleasure in doing things?

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

2. Feeling down, depressed or hopeless?

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

3. Trouble falling or staying asleep, or sleeping too much?

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

4. Feeling tired or having little energy?

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

5. Poor appetite or overeating?

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down?

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

7. Trouble concentrating on things, such as reading the newspaper or watching television?

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual?

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

9. Thoughts that you would be better off dead, or of hurting yourself in some way?

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

10. Have you ever taken medication or received counseling for depression, anxiety or any other mood disorder? Yes No

Provider Signature X: _____ Date. _____