



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

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: Records@amgqc.com



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)*

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

Other diseases not listed above: _____

Hospitalizations/Significant injuries: _____

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

- | | | |
|---|--|---|
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Heart Valve Surgery | <input type="checkbox"/> Kidney Surgery |
| <input type="checkbox"/> Bladder Suspension | <input type="checkbox"/> Heart Angioplasty (balloon) | <input type="checkbox"/> Organ Transplant |
| <input type="checkbox"/> Colon/Rectal surgery | <input type="checkbox"/> Heart Stents | <input type="checkbox"/> Orthopedic Surgery |
| <input type="checkbox"/> Dental Surgery | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Prostate Surgery |

- Eye Surgery
- Gallbladder
- Heart Surgery
- Heart Bypass
- Hysterectomy
- Complete Partial
- Hernia
- Joint Replacement
- Sinus Surgery
- Thyroid Surgery
- Tonsils and/ or Adenoids
- Tubal Ligation
- Vasectomy

Other surgery not listed above: _____

Previous reaction to anesthesia: (explain) _____



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

MEDICATION/FOOD/ENVIRONEMENTAL	REACTION

ALLERGIES OR REACTIONS

Preferred Local Pharmacy

Name: _____ Phone Number: _____
 Address: _____ City: _____ State: _____ Zip: _____

Mail order Pharmacy

Name: _____ Phone Number: _____
 Address: _____ City: _____ State: _____ Zip: _____



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)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Addiction Problems | <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Prostate Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> 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: _____