Bloom Family Health & Wellness
Patient Intake Form

Personal Information

Full Name: _____ **Date of Birth:** _____/_____/_____
Gender: ☐ Male ☐ Female ☐ Other
Address: _____
City: _____ **State:** _____ **ZIP Code:** _____
Phone Number: (_____)_____ **Email Address:** _____
Emergency Contact: _____**Relationship:** _____
Phone Number: _____

Medications

Please list all current medications:

1. _____
2. _____
3. _____
4. _____
5. _____

☐ **Check if additional medications are listed on a separate page**

Social History

- **Tobacco Use:** ☐ Never ☐ Former ☐ Current (How many Packs Per day/week -_____)
- **Alcohol Use:** ☐ Never ☐ Occasionally ☐ Regularly (How many drinks _____ per day/week/month/year)
- **Drug Use:** ☐ Never ☐ Occasionally ☐ Regularly (If yes, what type/kind_____)
- **Exercise:** ☐ None ☐ 1-2 times/week ☐ 3-4 times/week ☐ 5+ times/week
  (If yes, what type/kind_____)
- **Diet:** ☐ Balanced ☐ Vegetarian ☐ Vegan ☐ Other: _____

Health History

Please check any conditions you have been diagnosed with:

Cardiovascular	Respiratory	Gastrointestinal	Neurological	Endocrine
☐ Hypertension	☐ Asthma	☐ GERD	☐ Seizures	☐ Diabetes
☐ Heart Disease	☐ COPD	☐ Ulcers	☐ Migraines	☐ Thyroid Disorder
☐ High Cholesterol	☐ Chronic Bronchitis	☐ IBS	☐ Multiple Sclerosis	☐ Adrenal Disorder
☐ Stroke	☐ Emphysema	☐ Crohn's Disease	☐ Parkinson's Disease	☐ Pituitary Disorder

Musculoskeletal	Genitourinary	Dermatological	Psychiatric
☐ Arthritis	☐ Kidney Disease	☐ Eczema	☐ Depression
☐ Osteoporosis	☐ Bladder Disease	☐ Psoriasis	☐ Anxiety
☐ Gout	☐ Prostate Issues	☐ Skin Cancer	☐ Bipolar Disorder
☐ Fibromyalgia	☐ UTIs	☐ Acne	☐ Schizophrenia

Family History

Please check any conditions that apply to your immediate family members:

Cardiovascular	Respiratory	Gastrointestinal	Neurological	Endocrine
☐ Hypertension	☐ Asthma	☐ GERD	☐ Seizures	☐ Diabetes
☐ Heart Disease	☐ COPD	☐ Ulcers	☐ Migraines	☐ Thyroid Disorder
☐ High Cholesterol	☐ Chronic Bronchitis	☐ IBS	☐ Multiple Sclerosis	☐ Adrenal Disorder
☐ Stroke	☐ Emphysema	☐ Crohn's Disease	☐ Parkinson's Disease	☐ Pituitary Disorder

Musculoskeletal	Genitourinary	Psychiatric	Dermatological
☐ Arthritis	☐ Kidney Disease	☐ Depression	☐ Eczema
☐ Osteoporosis	☐ Bladder Disease	☐ Anxiety	☐ Psoriasis
☐ Gout	☐ Prostate Issues	☐ Bipolar Disorder	☐ Skin Cancer
☐ Fibromyalgia	☐ UTIs	☐ Schizophrenia	☐ Acne

Surgical History

Please check any surgeries you have had and provide the date(s):

General	Cardiovascular	Respiratory	Gastrointestinal	Neurological
☐ Appendectomy	☐ Pacemaker	☐ Lung Surgery	☐ Colonoscopy/EGD	☐ Brain Surgery
☐ Hernia Repair	☐ Angioplasty	☐ Bronchoscopy	☐ Colon Surgery	☐ Spinal Surgery
☐ Gallbladder Removal	☐ Heart Bypass	☐ Thoracotomy	☐ Bariatric Surgery	
DOS: ____/____/___	**DOS:** ___/___/___	**DOS:** ____/____/____	**DOS:** ____/____/____	**DOS:** ___/____/___

Orthopedic	Gynecological	Urological	Other
☐ Joint Replacement	☐ Hysterectomy (Total or Partial)	☐ Kidney Surgery	☐ Cosmetic Surgery
☐ Fracture Repair	☐ C-section	☐ Bladder Surgery	☐ Biopsy
☐ Arthroscopy	☐ Ovarian Surgery	☐ Prostate Surgery	☐ Other: _____
☐ Carpal Tunnel Release			
DOS: ____/___/_____	**DOS:** ____/___/_____	**DOS:** ____/___/_____	**DOS:** ____/___/_____

Hospitalizations

- **Reason for Hospitalization:** _____**Date(s):**_____
- **Reason for Hospitalization:** _____**Date(s):**_____
- **Reason for Hospitalization:** _____**Date(s):**_____

Signature: _____ **Date:** _____/_____/_____