**Bloom Family Health & Wellness**
**Patient Intake Form**

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## 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:** _____

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## Medications

**Preferred Pharmacy:** _____
**City/State:** _____
**Phone Number:** _____

**Please list all current medications:**

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

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

## Allergies/Medication Allergies:

| Allergies/Medication Allergies | Specific Allergen | Reaction | Severity |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## 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: _____
- **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other: _____
- **Children:** ☐ Yes, number of children: _____ ☐ No
- **Sexual Orientation:** ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Other: _____
- **Employment:** ☐ Employed ☐ Unemployed ☐ Retired ☐ Student ☐ Other: _____
- **Occupation:** _____

## Health History

| 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 | Other (not listed) |
|---|---|---|---|---|
| ☐ Arthritis | ☐ Kidney Disease | ☐ Eczema | ☐ Depression | ☐_____ |
| ☐ Osteoporosis | ☐ Bladder Disease | ☐ Psoriasis | ☐ Anxiety | ☐_____ |
| ☐ Gout | ☐ Prostate Issues | ☐ Skin Cancer | ☐ Bipolar Disorder | ☐_____ |
| ☐ Fibromyalgia | ☐ UTIs | ☐ Acne | ☐ Schizophrenia | ☐_____ |
| | | | | ☐_____ |

**Cancer**

- ☐ Breast Cancer
- ☐ Prostate Cancer
- ☐ Colon Cancer
- ☐ Skin Cancer _____
- ☐ Leukemia or Lymphoma

**Other Cancer(s) not listed:**

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

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

***Key:** M - Mother; F - Father; PGF - Paternal Grandfather; PGM - Paternal Grandmother; MGF - Maternal Grandfather; MGM - Maternal Grandmother; S- Sister; B - Brother*

| 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 | Cancer | Other (not listed) |
|---|---|---|---|---|---|
| ☐ Arthritis | ☐ Kidney Disease | ☐ Depression | ☐ Eczema | ☐ Breast Cancer | ☐_____ |
| ☐ Osteoporosis | ☐ Bladder Disease | ☐ Anxiety | ☐ Psoriasis | ☐ Prostate Cancer | ☐_____ |
| ☐ Gout | ☐ Prostate Issues | ☐ Bipolar Disorder | ☐ Skin Cancer | ☐ Colon Cancer | ☐_____ |
| ☐ Fibromyalgia | ☐ UTIs | ☐ Schizophrenia | ☐ Acne | ☐ Skin Cancer | ☐_____ |
| | | | | ☐ Leukemia or Lymphoma | ☐_____ |

## 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:** _____/_____/_____