SEQUIM MEDICAL ASSOCIATES, PLLP
New Patient Intake

Patient Name: _____ Date: _____

Age: _____

CONCERNS YOU WOULD LIKE ADDRESSED TODAY:

_____

_____

_____

PAST/CURRENT MEDICAL PROBLEMS:

_____

_____

_____

_____

_____

PAST SURGERIES (list dates):

_____

_____

_____

_____

MARITAL STATUS (please circle): Married / Single / Divorced / Widowed Number of children: _____

CURRENT / PAST WORK: _____

Any occupational exposures or concerns? _____

HOBBIES & LIESURE ACTIVITIES: _____

TOBACCO USE: How much? _____ How many years? _____ If quit, when? _____

ALCOHOL USE: (# and type drinks) _____ per day / week / month / year

CAFFEINE: (# and type of drinks per day): _____

EXERCISE: (current amount and type): _____

DIET: _____

FAMILY HISTORY/Living and Deceased (cancers, strokes, heart attacks, health problems / age at death):

Mother: _____ Father: _____

Brothers: _____ Sisters _____

Children: _____

Maternal Grandmother: _____ Maternal Grandfather: _____

Paternal Grandmother: _____ Paternal Grandfather: _____

PLEASE CONTINUE ON BACK…

MEDICINE ALLERGIES (list reaction): _____

_____

CURRENT MEDICATIONS (List all Prescription, Herbal, Over the counter):

Medication:	Milligram:	How often do you take:
Medication:	Milligram:	How often do you take:
Medication:	Milligram:	How often do you take:
Medication:	Milligram:	How often do you take:
Medication:	Milligram:	How often do you take:
Medication:	Milligram:	How often do you take:

_____ No additional medications such as pain medicines, benzodiazepines (Hydrocodone, Oxycodone, Xanax, Valium, Ambien etc.) have been omitted from the list, as these will not be filled unless you have listed them here. Please initial.

(If more room needed, add on separate paper)

WOMEN'S HEALTH Please Provide Dates: # pregnancies: _____ # live births: _____ Last menstrual period: _____

Date of last Mammogram: _____ Pap smear: _____

Hormone replacement: Current / Previous / Never. If stopped, when: _____

HEALTH MAINTENANCE Please Provide Dates:

DEXA / Bone Density scan: _____ Colonoscopy / Flexible sigmoidoscopy: _____

Tetanus (Please Circle) Td / TDAP: _____ Pneumonia Vac: Prevnar 13_____Pnuemo 23_____

Flu Vac: _____ Zostavax: _____ Shingrix: 1st Dose_____2nd Dose _____

Covid Vac 1st Dose:_____ 2nd Dose: _____ Booster:_____

Last Physical: _____ Routine Labs (cholesterol, etc.): _____ Last eye exam: _____

Cardiac stress testing: _____ Height _____

SPECIALISTS: List other physicians you see: _____

_____

Do you have an Advanced Medical Directive / Living Will: (Please Circle) YES NO If yes, please provide a copy for our records.

Are you having problems with…? (Check all that apply):

☐ fevers	☐ heartburn	☐ rashes
☐ chills	☐ nausea	☐ lumps
☐ fatigue	☐ vomiting	☐ itching
☐ weight change	☐ constipation	☐ skin changes
☐ vision changes	☐ diarrhea	☐ hair or nail changes
☐ hearing changes	☐ abdominal pain	☐ headache
☐ runny nose	☐ urinary problems	☐ dizziness
☐ sinus problems	☐ vaginal problems	☐ weakness
☐ cough	☐ sexual problems	☐ numbness
☐ wheezing	☐ breast lumps	☐ tingling
☐ excessive snoring	☐ breast pain	☐ stress
☐ chest pain	☐ nipple discharge	☐ anxiety
☐ palpitations	☐ muscle aches	☐ depression
☐ trouble breathing	☐ joint aches	☐ memory problems
☐ leg swelling	☐ back pain	☐ trouble sleeping