ELECTRONIC HEALTH RECORDS INTAKE FORM

First Name: _____ **Last Name**: _____

Smoking Status (circle one):

Every Day Smoker	Occasional Smoker	Former Smoker	Never Smoked

Family Medical History ***(Record one diagnosis in your family history and the affected relative)***				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)

Are You Currently Taking Any Medication? Include Regularly Used Over the Counter Meds

Medication Name	Dosage & Frequency (i.e. 5mg once a day)

Do You Have Any Medication Allergies?

Medication Name	Reaction	Onset Date If Known	Additional Comments

Patient Signature: _____ **Date**: _____

For Office Use Only

Height:_____ Weight:_____ Blood Pressure:_____

Alerts Input: Provider___ Front Desk:_____
Family Hx:_____
Meds Input:____
Allergies Input: ____
Vital Input: notes: ____ Dashboard:___
Office Manager Check: _____
Ok to Scan in:_____