Grand Valley Primary Care Community HOSPITAL

Lifestyle Medicine Program

Intake Form

PATIENT INFORMATION

Name: _____ **Date of Birth:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number: _____ **E-mail Address:** _____

Occupation: _____ **Marital Status:** _____

Primary Care Provider: _____ **Date of Last Exam:** _____

Other Doctors Seen in the Past Year: _____

_____

EMERGENCY CONTACT

Emergency Contact Name: _____ **Relationship:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Emergency Contact Phone Number: _____

HEALTH HISTORY

Are you Pregnant? ___No ___Yes (Due Date: _____)

Anxiety	No	Yes	High Cholesterol	No	Yes
Arthritis	No	Yes	Insomnia	No	Yes
Cancer	No	Yes	Kidney Disease	No	Yes
Depression	No	Yes	Migraine Headache	No	Yes
Diabetes	No	Yes	Obstructive Sleep Apnea	No	Yes
Gout	No	Yes	Osteoporosis	No	Yes
Heart Disease	No	Yes	Thyroid Disorder	No	Yes
High Blood Pressure	No	Yes	Stroke	No	Yes

Other: _____

Previous Surgeries: _____

Food Intolerances/Allergies: _____

Medication Intolerances/Allergies: _____

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HEALTH HISTORY CONT.

Please List All Prescribed Medicaiton, Supplements & Over-the-Counter Medications:

_____

_____

_____

FAMILY MEDICAL HISTORY

Anxiety	No	Yes	High Cholesterol	No	Yes
Arthritis	No	Yes	Insomnia	No	Yes
Cancer	No	Yes	Kidney Disease	No	Yes
Depression	No	Yes	Migraine Headache	No	Yes
Diabetes	No	Yes	Obstructive Sleep Apnea	No	Yes
Gout	No	Yes	Osteoporosis	No	Yes
Heart Disease	No	Yes	Thyroid Disorder	No	Yes
High Blood Pressure	No	Yes	Stroke	No	Yes

Other: _____

SOCIAL HISTORY

Do you use tobacco products? ___No ___ Yes

If yes, please describe: _____

How many alcoholic beverages do you drink in a week? _____

Do You Live Alone? ___ No ___ Yes

If you don't live alone, who lives with you? _____

Who does the grocery shopping? _____ How often? _____

Who does most of the cooking? _____

If given a recipe would you prefer: ___ Someone else cook it OR ___ Cook it yourself

How often do you eat out? _____ Where? _____

Have you made any changes to your diet recently? ___ No ___ Yes

If yes, please explain: _____

Is there anything else you feel we should know: _____

_____

_____