Mother of Mercy Free Medical Clinic
PATIENT INTAKE FORM

Pt. ID #_____

PATIENT DATA:

Patient Name:_____ DOB: _____

Sex: M/F Home Phone #:_____ Cell Phone #: _____

Address:_____

City: _____ State: _____ Zip: _____

PATIENT HISTORY:

Reasons for Visit: (symptoms, onset, diagnoses, duration, etc.):_____

_____

_____

Family History: (diabetes, etc.): _____

_____

Surgical History: _____

_____

Allergies: _____

_____

Medications: (including Supplements, Vitamins, Herbs, OTC Drugs): _____

_____

_____

Social History:

Occupation: _____ Are you currently employed ❑ yes ❑ no

Number of children: _____ Education Grade: _____

Able to care for self: ❑ yes ❑ no Live: ❑ alone ❑ with others

Hard of hearing: ❑ yes ❑ no Deaf: ❑ one ear Right or Left ❑ both ears

Legally blind in one or both eyes: ❑ yes ❑ no

Exercise level: ❑ none ❑ occasional ❑ moderate ❑ heavy

General stress level: ❑ low ❑ medium ❑ High

Diet: ❑ regular ❑ vegetarian ❑ vegan ❑ gluten free ❑ cardiac ❑ diabetic

Caffeine intake: ❑ none ❑ occasional ❑ moderate ❑ heavy

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Alcohol intake: ❑ none ❑ occasional ❑ moderate ❑ heavy

Smoking status: ❑ never ❑ former ❑ currently If yes, packs per day:_____

Has smoked since age: _____ Total Tobacco-years of use: _____

Chewing tobacco:	❑ yes ❑ no	Passive smoke exposure:	❑ yes ❑ no
Illicit drugs:	❑ yes ❑ no	Guns present in home:	❑ yes ❑ no
Smoke alarm in home:	❑ yes ❑ no	Seat belts used routinely:	❑ yes ❑ no
Sunscreen used routinely:	❑ yes ❑ no	Performs monthly self-breast exam:	❑ yes ❑ no
Advance directive:	❑ yes ❑ no	Is the patient ambulatory:	❑ yes ❑ no

Within the past 12 months the food we bought just didn't last and we didn't have money to get more

❑ often True ❑ sometimes True ❑ never True

Within the past 12 months we worried whether our food would run out before we got money to buy more.

❑ often True ❑ sometimes True ❑ never True

MEDICAL HISTORY:

Past Medical History:

For the following, please check if you have the condition or have had the condition in the past.

- ❑ ADD/ADHD
- ❑ Abuse/Domestic Violence
- ❑ Allergies/Hayfever
- ❑ Acid Reflux (GERD)
- ❑ Anemia
- ❑ Anesthesia complications
- ❑ Anxiety Disorder
- ❑ Arthritis
- ❑ Asthma
- ❑ Bladder or Kidney Problems
- ❑ Blood diseases
- ❑ Blood transfusion
- ❑ Breast cancer
- ❑ Breast problem
- ❑ COPD
- ❑ Cancer
- ❑ Chicken Pox
- ❑ Chronic Ear Infections
- ❑ Constipation
- ❑ Coronary Artery Disease
- ❑ Depression
- ❑ Developmental or Behavioral Disorders
- ❑ Diabetes
- ❑ Difficulty Swallowing
- ❑ Diverticulitis
- ❑ Ear or Hearing Problems
- ❑ Eating Disorder
- ❑ Eczema
- ❑ Endometriosis
- ❑ Fibromyalgia
- ❑ GI Problems
- ❑ Gout
- ❑ Headaches
- ❑ Heart Disease
- ❑ Heart Problems
- ❑ Hepatitis
- ❑ High Cholesterol
- ❑ Hospitalizations
- ❑ Hypertension
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Infertility
- ❑ Kidney Disease
- ❑ Kidney Stones
- ❑ Liver Disease
- ❑ Lung Disease
- ❑ Meniere's Disease
- ❑ Mental Illness
- ❑ Muscle, Joint, or Bone Problems
- ❑ Osteoporosis
- ❑ Other
- ❑ Ovarian Cancer
- ❑ Polyps
- ❑ Pre-Eclampsia
- ❑ Pulmonary Embolism
- ❑ Reflux/GERD
- ❑ Seizures/Epilepsy
- ❑ Skin Problems
- ❑ Stroke
- ❑ Thrombophilias
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Varicosities
- ❑ Vision or Eye Problems

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DATOS DEL PACIENTE:

Nombre del paciente:_____ Fecha de nacimiento: _____

Sex: M/F Numero de telefono:_____ Numero de celular: _____

Direccion:_____

Ciudad: _____ Estado: _____ C.P.: _____

Historia del paciente:

Razon de la visita: (sintomas, onset, diagnostico, duracion, etc.):_____

_____

_____

Historia Familiar: (diabetes, etc.): _____

_____

Cirugias: _____

_____

Alergias: _____

_____

Medicacion: (incluyendo suplementos, Vitaminas, Hiervas, Otras drogas): _____

_____

_____

Historia social:

Ocupacion: _____ Esta actualmente empleado ❑ si ❑ no

Hijos: _____ Grado de educacion: _____

Puede valerse por si mismo: ❑ si ❑ no vive: ❑ solo ❑con otros

Dificultad para escuchar: ❑ si ❑ no sordera : ❑ derecho o izquierdo ❑dos oidos

Legally blind in one or both eyes: ❑ si ❑ no

Nivel de ejercicio: ❑ ninguno ❑ ocasional ❑ moderado ❑ mucho

Nivel general de estres: ❑ bajo ❑ medio ❑ alto

Dieta: ❑ regular ❑ vegetarian ❑ vegana ❑ libre de gluten ❑ cardiaca ❑ diabetica

Consume de cafeina: ❑ nada ❑ ocasional ❑ moderado ❑ mucho

Ingesta de alcohol: ❑ nada ❑ ocasional ❑ moderado ❑ mucho

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Fuma : ❑ nunca ❑ ex ❑ actualmente # de paquetes por dia:_____

Desde que edad fuma: _____ Total d anos de uso de tabaco: _____

Drogas ilicitas:	❑ si	❑ no	exposicion pasiva a tabaco:	❑si	❑ no
Illicit drugs:	❑ si	❑ no	Armas presents en casa:	❑ si	❑ no
Detector de humo en casa:	❑ si	❑ no	uso de correa de seguridad en el carro:	❑ si	❑ no
Uso de protector de sol:	❑ si	❑ no	Haces autoexamenes de las mamas:	❑ si	❑ no
Directiva medica:	❑ si	❑ no	Es el paciente ambulatorio:	❑ si	❑ no

En los ultimos 12 meses, la comida que compramos no duro y no tuvimos suficiente dinero para obtener mas

❑ amenudo cierto ❑ a veces cierto ❑ nunca es verdad

En los ultimos 12 meses, fuimos preocupados por tener suficiente comida y dinero para obtener mas comida

❑ amenudo cierto ❑ a veces cierto ❑ nunca es verdad

Historial Medico:

Historia Medica Pasada:

For the following, please check if you have the condition or have had the condition in the past.

- ❑ Trastorno por déficit de atención con hiperactividad
- ❑ Abuso o violencia domestica
- ❑ Alergias\ fiebre alta
- ❑ Reflujo gastrico
- ❑ Anemia
- ❑ Complicaciones con la anesthesia.
- ❑ Desorden de ansiedad
- ❑ artritis
- ❑ Asma
- ❑ Problemas de rinon o vejiga
- ❑ Enfermedad de la sangre
- ❑ Transfusion de sangre
- ❑ Cancer de mama
- ❑ Problemas en los pechos
- ❑ COPD
- ❑ Cancer
- ❑ Varicela
- ❑ Infecciones cronicas del oido
- ❑ Constipacion
- ❑ Enfermedad de las arterias coronarias.
- ❑ Depresion
- ❑ Desordenes de comportamieno
- ❑ Diabetes
- ❑ Dificultad al tragar
- ❑ Diverticulitis
- ❑ Problemas para escuchar
- ❑ Desordenes alimenticios
- ❑ Eczema
- ❑ Endometriosis
- ❑ Fibromialgia
- ❑ Problemas del tracto intestinal
- ❑ Gota
- ❑ Dolor de cabeza
- ❑ Enfermedades del Corazon
- ❑ Problemas cardiacos
- ❑ Hepatitis
- ❑ Colesterol alto
- ❑ Hospitalizaciones
- ❑ Hipertension
- ❑ Hipertiroidismo
- ❑ Hipotiroidismo
- ❑ Infertilidad
- ❑ Enfermedades del rinon
- ❑ Calculos renales
- ❑ Enfermedades del higado
- ❑ Enfermedades del pulmon
- ❑ Meniere's Disease
- ❑ Enfermedades mentales
- ❑ Problemas Muscular, articular, oseos
- ❑ Osteoporosis
- ❑ Otros
- ❑ Cancer de ovario
- ❑ Polipos
- ❑ Preclampcia
- ❑ Embolismo pulmonar
- ❑ Reflujo
- ❑ Ataques epilepticos
- ❑ Problemas de la piel
- ❑ Derrame Cerebral
- ❑ Thrombophilias
- ❑ Problemas tiroideos
- ❑ Tuberculosis
- ❑ Varicosidades
- ❑ Problemas visuales