Focused Women's Healthcare

Male Intake Form: PATIENT INFORMATION **Date:**_____

NAME: _____/_____/_____
(Last) (First) (M.I.)

SSN:_____DOB:_____ GENDER:_____

ADDRESS: _____/_____/_____
(street or PO Box) (city & state) (zip)

PHONE: M:_____ H:_____W:_____
E-Mail_____

OCCUPATION_____EMPLOYER_____

ALLERGIES:_____
List ALL MEDICATIONS you take, including over-the-counter medications/vitamins.

_____

_____

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

Anemia
Anxiety
Arrhythmia (irregular heart beat)
Asthma
Bipolar
Cancer: (type and year diagnosed)_____
Crohn's Disease
Ulcerative Colitis
COPD/ Emphysema
Depression
Diabetes
DVT (Blood Clot)/ Pulmonary Embolus
GERD (Acid Reflux)
Heart Disease
High Blood Pressure
High Cholesterol
HIV
Hepatitis
Irritable Bowel Syndrome
Lupus
Stroke
Thyroid Disorder

Other Medical Problems_____

Last Colonoscopy: _____

PSA testing: _____

Focused Women's Healthcare, PLLC
1028 Lee Ann Drive NE, Suite #100
Concord, NC 28025
Ph: 704-262-3338
Fax: 704-706-3073

Please circle any of the following symptoms that apply:
Fatigue
Low energy
Erectile dysfunction
Weight gain
Decreased libido/ sexual desire

Prior Surgery-
Please list any other surgical procedures_____

Social History-
Smoking/Tobacco use: ____current ____never ____past (type_____)

Alcohol use: ____current ____never ____past (drinks/week_____)

Recreational Drug use: ____current ____never ____past (type_____)

Family History: (list any important disease or issue with parents, grand-parents, or siblings)

_____
_____

Please list any other medical providers you see on a regular basis

_____
_____

Please list any other issues or concerns not addressed above

_____
_____

Is there anyone you would like to add to your emergency contacts or Health Care Proxy in our system?

Name: _____

Relationship to patient: _____

Phone number: _____

Signature:_____ **Date:**_____