Patient Name:	
Athena ID:	
Today's Date:	
	For office use only

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CLINICAL INTAKE FORM		
PLEASE FILL OUT THE FOLLOWING INFORMATION AS	COMPLETELY AS POSSIBLE.	
Primary Pharmacy:	Secondary Pharmacy:	
Preferred imaging Facility:		
Current Specialist Care Team		
1. 2.		
3.		
4. 5.		
Allergies:	<u> </u>	
Current Medication List: Please include medication na		
Medication Name	Dosage	Frequency

Medication Name	Dosage	Frequency
	· ·	
	<u> </u>	

Family History: No significant family history	☐ Unknown	
Mother:	Father:	
Siblings:		
Other:	Please indicate if G Maternal or Paterna	
Social History		
Tobacco Smoking Status: Never	Current Smoker Former Smok	er
If you are a former smoker, when was your quit date?		
If you are a current smoker, how much do you smoke?	pack(s) per day	
Have you ever used any other forms of tobacco or nicoti	ne? Yes No	
Alcohol Intake: None Moderate	Occasional Heavy	
Do you use any illicit or recreational drugs? Yes	No	
Marital Status: Single Married	Divorced Widowed	
Are you sexually active? Yes No		
Number of Children:		
Occupation:		<u></u>
Diet: Regular Vegetarian	Oth	ner
Exercise Level: None Model	ate Occasional He	avy
Advanced Directive:YesNo		
Gender Identity		
Gender Identity: Female Male	_ Transgender Other	
Sex Assigned at Birth: Female Male		
Sexual Orientation: Heterosexual Hom	osexual BisexualC	Other

Surgical History: Please list all surgeries with dates					
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Past Medical History: Please list any past medical he	ealth conditions				
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Preventive Care: If known, please list the dates of th blank.	e following scre	enings/vaccination	s. If not applicabl	e, please write I	N/A or leave
Pap Smear:	Mammogran	າ:			
Bone Density:	Colonoscopy	:			
Pneumonia Vaccine:	Flu Vaccine: _				
Shingles Vaccine:	Tetanus Vaccir	ne:			
COVID Vaccine:					