



NEW PATIENT INTAKE FORM

Rowan Tree Medical, P.A.
2500 NE 15th Avenue
Wilton Manors, FL 33305

Today's Date: _____

Legal Name: _____

Sex: Male Female Date of Birth: _____

Marital Status: _____ Race: _____ Age: _____

Home Address: _____

Mailing Address (if different): _____

Primary Telephone #: _____ Cell: ___ Home: ___ Work: ___

Secondary Telephone #: _____ Cell: ___ Home: ___ Work: ___

Country of Birth: _____ Occupation: _____

Emergency Contact Name: _____

Emergency Contact Number: _____

Emergency Contact Relationship to you: _____

Email Address: _____

How did you hear about Rowan Tree Medical? _____

Primary Insurance Company: _____ Social Security Number: _____

Secondary Insurance Company: _____

What is the reason for this visit: _____

How long have you had this condition: _____

What treatments have you tried? How did your condition change? _____

Do you have any allergies?

Number of cigarettes per day: ___ If NONE, have you ever smoked? ___ When did you quit? _____

Number of drinks per week: ___ If NONE, have you ever drank? ___ When did you quit? _____

Family History:

Mother: Deceased? Y N Health issues: _____

Father: Deceased? Y N Health issues: _____

Sibling(s) Deceased? Y N Health issues: _____

What medications are you currently taking:

Medical History

Please check all that apply:

<input type="checkbox"/>	Addiction _____
<input type="checkbox"/>	AIDS
<input type="checkbox"/>	Alcoholism
<input type="checkbox"/>	Allergic Rhinitis
<input type="checkbox"/>	Anemia
<input type="checkbox"/>	Appendicitis
<input type="checkbox"/>	Arteriosclerosis
<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Balance issues
<input type="checkbox"/>	Breast Lumps
<input type="checkbox"/>	Breathing Problems
<input type="checkbox"/>	Bronchitis
<input type="checkbox"/>	Bursitis
<input type="checkbox"/>	Cancer _____
<input type="checkbox"/>	Candida
<input type="checkbox"/>	Chest Pain
<input type="checkbox"/>	Chicken Pox
<input type="checkbox"/>	Chronic Fatigue
<input type="checkbox"/>	Colitis/Bowel Disease
<input type="checkbox"/>	Depression
<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Digestive Disorders
<input type="checkbox"/>	Ear Lavage
<input type="checkbox"/>	Eating Disorders
<input type="checkbox"/>	Elevated Liver Enzymes
<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	Fever/Chills
<input type="checkbox"/>	Fibromyalgia
<input type="checkbox"/>	Gall Stones
<input type="checkbox"/>	

<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	Goiter
<input type="checkbox"/>	Gout
<input type="checkbox"/>	Hair Loss
<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	Hernia
<input type="checkbox"/>	Hepatitis _____
<input type="checkbox"/>	Herpes
<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	High Cholesterol
<input type="checkbox"/>	HIV
<input type="checkbox"/>	Hypertension
<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	Meningitis
<input type="checkbox"/>	Mononucleosis
<input type="checkbox"/>	Multiple Sclerosis
<input type="checkbox"/>	Nephritis
<input type="checkbox"/>	Neuralgia
<input type="checkbox"/>	Night Sweats
<input type="checkbox"/>	Paralysis
<input type="checkbox"/>	Prostate Problems
<input type="checkbox"/>	Rheumatism
<input type="checkbox"/>	Scarlet Fever
<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Sinus Congestion
<input type="checkbox"/>	Stroke
<input type="checkbox"/>	STD
<input type="checkbox"/>	Thyroid Problems
<input type="checkbox"/>	Tonsillitis
<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	Urinary Problems

Other Illnesses: _____

Surgeries: _____

Do you have **Advance Directives** or a **Living Will**?

Yes ____ No ____

Does **Domestic Violence** affect your life?

Yes ____ No ____