

**Initial Intake**

Chapel Hill Primary Care  
55 Vilcom Circle, Suite 110  
Chapel Hill, NC 27514

Name:	Occupation
Address:	City/State/Zip
Phone: (home)	(work)
E-Mail Address:	
Date of Birth:	Referred by:
Emergency Contact:	

**Please enter the following information:**

What is your primary reason for seeing the doctor today? What concerns would you like addressed?

(1) \_\_\_\_\_

(2) \_\_\_\_\_

(3) \_\_\_\_\_

**Medical Profile**

(May continue on back if needed)

Previous medical diagnoses:			
_____			
Previous surgery/hospitalization	Y	N	If Y, explain:
Accident/injury	Y	N	If Y, explain:
List current medications and supplements, with their doses			
_____			
Allergies:			
_____			

**Mark all conditions you have had or currently experience:**

X	Condition	Past	Present (within 1 year)	X	Condition	Past	Present (within 1 year)
	Allergies				Kidney disease		
	Aneurysm				Obesity		
	Angina				Osteo/rheumatoid arthritis		
	Asthma				Osteoporosis		
	Cancer				Pacemaker		
	Depression/anxiety				Phlebitis/blood clots		
	Diabetes				Reflux		
	Disc problems				Seizures		
	Emphysema				Stroke		
	Fractures				Ulcer		
	Heart surgery/CABG				Varicose veins		
	Hepatitis/liver disease						
	Hernia						
	High blood pressure						
	High cholesterol						
	Irritable bowel						
	Joint injuries						

Please describe your diet and exercise habits. \_\_\_\_\_

Do you smoke? \_\_\_\_\_ Have you ever smoked? \_\_\_\_\_ If yes, how much? \_\_\_\_\_

Do you drink alcoholic beverages? \_\_\_\_\_ Have you ever? \_\_\_\_\_ If yes, in the past 4 months, how much and how often? \_\_\_\_\_

Date of your last

Pap smear	Tetanus shot	Mammogram
Bone density	Colonoscopy	

Is there anything else about your health history you feel we need to know? \_\_\_\_\_

What do you do to manage stress in your life? \_\_\_\_\_

Family history

Condition	Parents	Grandparents	Siblings	Children
Alzheimer's				
Cancer				
Diabetes				
Heart disease				
High blood pressure				
Stroke				
Other				