

AZUREWAVE MEDICAL SERVICES

Comprehensive New Patient Medical History & Intake Packet

SECTION 1 – PATIENT INFORMATION

Full Legal Name:

Preferred Name:

Date of Birth:

Sex at Birth:

Gender Identity (optional):

Address:

City / State / ZIP:

Primary Phone:

Secondary Phone:

Email:

Occupation:

Employer:

Marital Status:

EMERGENCY CONTACT

Name:

Relationship:

Phone:

SECTION 2 – INSURANCE (If Applicable)

Insurance Company:

Member ID:

Group Number:

Subscriber Name:

Subscriber DOB:

Secondary Insurance:

SECTION 3 – PHARMACY

Pharmacy Name:

Address:

Phone:

SECTION 8 – PAST MEDICAL HISTORY (Circle all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Coronary Artery Disease |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Heart Failure |
| <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Diabetes Type 1 | <input type="checkbox"/> Diabetes Type 2 |
| <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Asthma | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> GERD | <input type="checkbox"/> IBS |
| <input type="checkbox"/> Inflammatory Bowel Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> CKD |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Migraines | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> PTSD |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Substance Use Disorder | |

Other Medical Conditions:

SECTION 9 – FAMILY HISTORY

Mother (Age, Alive/Deceased, Conditions):

Father (Age, Alive/Deceased, Conditions):

Siblings (Age, Alive/Deceased, Conditions):

Children (Age, Alive/Deceased, Conditions):

SECTION 10 – SOCIAL HISTORY

Smoking History

Do you currently smoke? Yes No

Type:

How many per day?:

How many years?:

If former smoker: Year quit:

Alcohol History

Do you drink alcohol? Yes No

Type(s):

Drinks per week:

History of heavy drinking? Yes No

Recreational Drug Use

Do you use recreational drugs? Yes No

Type(s):

Frequency:

History of IV drug use? Yes No

Exercise (Days per week? Type?):

Diet (Pattern / restrictions):

Sleep (Hours per night? Quality?):

PATIENT SIGNATURE

I certify that the above information is accurate to the best of my knowledge.

Patient Signature:

Date:
