Completing this optional form will help your new primary care provider get to know you better and provide you the best possible care. This information will become part of your medical record and is protected by VA Privacy Policy.

San Francisco VA
New Patient Intake Form

Name: ________________________ **Social Security Number (Last 4 only):** _______

Name/Title you prefer we use: ____________________ **Date:** ________________

Pronouns: **Gender Identity:** **Gender Assigned at Birth:**

1. What matters most in your life right now? ____

____

2. What matters most to you regarding your health and well-being today? ______________

____

3. When was the last time you felt well? This may be now or a time in the past.
What was going on in your life at that time?

____

4.What are things you want your care team to know about YOU? (for example: race/ethnicity, sexual identity, job/profession/career)

____

5. Prior Primary Care Provider or where have you been getting health care?

____

6 Who is your emergency contact? Name: ______________________________

Relationship to You: ________________ Phone Number: ______________________

7. What branch of the military did you serve in and when? ______________________________

8. What city/town do you live in? ____________________

9. Who do you live with (pets included)? __________________________
☐ **I live alone**

10. Are you concerned about losing your housing? ☐ **Yes** ☐ **No**

11. Do you feel safe at home? ☐ **Yes** ☐ **No**

12. Education

☐ High school/GED
☐ Trade school
☐ Some college
☐ College graduate
☐ Graduate school
☐ Other ____________

Turn Over →

9/16/2021

13. Past medical history

What medical conditions do you have now, or have you had in the past?

- ☐ **Diabetes**
- ☐ **Heart attack**
- ☐ **Stroke**
- ☐ **High blood pressure**
- ☐ **High cholesterol**
- ☐ **COPD/Emphysema**
- ☐ **Asthma**
- ☐ **Stomach Ulcer**
- ☐ **Anemia**
- ☐ **Thyroid trouble**
- ☐ **Prior blood clot**
- ☐ **Prostate trouble**
- ☐ **Vision difficulties**
- ☐ **Pain (where in your body?)** ______________________
- ☐ **Arthritis (where in your body?)** ______________________
- ☐ **Osteoporosis**
- ☐ **Bone fracture (where in your body?)** _________________
- ☐ **Headaches or Migraines**
- ☐ **Liver disease (Hepatitis B, Hepatitis C or Cirrhosis)**
- ☐ **Cancer (Type or where in your body)**______________________
- ☐ **Sexually transmitted infection (i.e. Herpes, Chlamydia)**
- ☐ **HIV Infection**
- ☐ **Depression**
- ☐ **Post Traumatic Stress Disorder**
- ☐ **Drug or alcohol use**
- ☐ **None of the above**

Other: ____

____

14. Hospitalizations

Have you ever been admitted overnight to a hospital? Please list where, when, and why. Please include hospitalizations for any medical OR psychiatric problems. *If none, write N/A*.

Reason ____ Hospital: ____________________ Date: ________

Reason ____ Hospital: ____________________ Date: ________

Reason ____ Hospital: ____________________ Date: ________

15. Surgeries

Have you had surgery before? Please list any surgical procedures you have undergone, including if you have had any devices implanted in your body (for example artificial joints or heart pacemaker) and the approximate date if you remember. *If none, write N/A*.

Surgery: ________________________ Date: ________ Surgery: ________________________Date: ________

Surgery: ________________________Date: ________ Surgery: ________________________Date: ________

Do you have any metal or other devices in your body? ☐ Yes ☐ No (If Yes – Location _______________)

16. Current Medications, Supplements and Herbs: *If none, write N/A*.

Do you have all your prescription bottles or a medication list with you today? ☐ Yes ☐ No

- If yes, please attach list and skip to **Allergies** section**.**
- If no, please include **all prescriptions, over the counter medications and supplements**.

Name of Medication/ Supplement/Herb	Dose	Frequency (i.e. Daily, Twice Daily, As needed)

17. Allergies

Do you have any allergies, or have you had a negative reaction to a medication? Please list the agent/drug and what happened. *If none, write N/A*.

Allergy	What Happened?

18. Are you currently experiencing any of the following?

☐ Abdominal pain	☐ Depression	☐ Hay fever	☐ Painful urination
☐ Anxiety	☐ Diarrhea	☐ Headache	☐ Runny nose
☐ Blood in stools	☐ Eye problems	☐ Heart palpitations	☐ Suicidal thoughts
☐ Bloody urine	☐ Ear pain	☐ Heat/cold intolerance	☐ Vomiting
☐ Bruising	☐ Excessive thirst	☐ Erection problems	☐ Memory Concerns
☐ Changing mole	☐ Extreme fatigue	☐ Joint pain	☐ Weight gain
☐ Chest pain	☐ Falling	☐ Muscle weakness	☐ Weight loss
☐ Constipation	☐ Fever	☐ Nausea	☐ Wheezing
☐ Cough	☐ Frequent urination	☐ Numbness	☐ Other: ____________

Turn Over →

19. Do you do any of the following?

• Use tobacco? ☐ **Yes** ☐ **No** ☐ **Former tobacco user, Quit Date ________**

How many per day? __________ How many years (or how old were you when you started)? ________

Exposure to second hand smoke? ☐ **Yes** ☐ **No**

• Drink alcohol? ☐ **Yes** ☐ **No**

____________ (write number) drinks per day/week/month (circle appropriate unit of time)

• Use marijuana, CBD, THC? ☐ **Yes** ☐ **No**

• Which of the following drugs or pills not prescribed to you do you use now, or have you used in the past? Circle all that apply

Methamphetamines or Prescription Stimulants	Opiates (Heroin, Fentanyl, Oxycodone, Vicodin, etc)	Benzos, Barbiturates, Z-drugs	Cocaine

Are you using any of these drugs currently? ☐ **Yes** ☐ **No**

20. Have you ever had a: *If none, write N/A.*

☐ Colonoscopy?
Where?____________________ When? _____________ Result: ☐ Normal ☐ Abnormal

☐ Cardiac stress test? (this might have included walking on a treadmill)

Where?____________________ When? _____________ Result: ☐ Normal ☐ Abnormal

21. Vaccinations/Prevention

Date of Last Tetanus Vaccination: ________________

Have you received any of the following vaccines?

Covid-19 Vaccine ☐ Yes ☐ No ☐ Not Sure

Hepatitis A ☐ Yes ☐ No ☐ Not Sure

Hepatitis B ☐ Yes ☐ No ☐ Not Sure

Pneumovax ☐ Yes ☐ No ☐ Not Sure

Prevnar ☐ Yes ☐ No ☐ Not Sure

Shingles Vaccine ☐ Yes ☐ No ☐ Not Sure

22. Gun safety is a health care priority. Do you have a gun in your home? ☐ **Yes** ☐ **No**
VA offers free trigger locks. Are interested in receiving one? ☐ **Yes** ☐ **No**

23. Family History

Are there medical conditions that run in your family? Please only include your direct family (parents, brothers and sisters, and children)

Disease in Family Member	Family member affected:
☐ Heart attack	
☐ Stroke	
☐ Diabetes	
☐ Cancer? What type? ___________________________	
☐ Autoimmune disease ___________________________ (examples: lupus, inflammatory bowel disease, rheumatoid arthritis)	
☐ Mental Health Condition (examples: depression, anxiety, addiction, suicide attempt)	
☐ Other Conditions	

24. Who is your power of attorney or healthcare proxy (person who you choose to make decisions about your care when you cannot communicate for yourself, i.e. in life-threatening situations):

Name of person and their relationship to you ____

25. Have you completed an advanced directive for healthcare or living will?

☐ Yes ☐ No

Please give this form to your provider at the start of the visit.

Staff only:

Provider: Once you are done with this form, leave it in your PACT MSA's mailbox

PACT MSA: Submit form to ROI for scanning. Form should be attached to MP Initial Note