DelCare Health Solutions, LLC
Medical Intake Form

Please complete all of the following as accurately as possible:

Name _____ Age _____ Birthdate _____ Sex _____

Address _____ City _____ Zip _____

Phone (H) _____ _____ (W) _____ _____

Occupation _____ Full Time / Part Time

Employer _____ Education Level _____

Married _____ Separated _____ Divorced _____ Widow _____ Single _____ Other _____

Children (ages) _____

How did you hear about us? _____

Are you familiar with Homeopathy? _____

What is the Level of Your Health? Excellent _____ Good _____ Fair _____ Poor _____

Please list your most concerning health care problems at this time (in order of importance to you):

1. _____
2. _____
3. _____
4. _____

When did your chief problem or illness begin? _____

What do you think may have caused your chief complaint?

_____

PAST MEDICAL HISTORY

Past Surgical History:

Please list any Surgical Procedures you have had and the approximate dates:

	Problem	***Dates***
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Past Medical History:

Please place a check next to any of the following that you have had:

_____ Heart Disease
_____ Stroke
_____ Diabetes
_____ Hypertension
_____ Asthma
_____ Allergies
_____ Eczema
_____ Depression
_____ Sexually Transmitted Disease
_____ HIV / AIDS
_____ Tuberculosis (TB)
_____ Polio
_____ Cancer
_____ Major Trauma

Indicate illness not listed: _____

_____

_____

_____

Family History:
Please Circle any of the following diseases tend to run in your family and list what relative (father, grandmother, etc.)

Diabetes: _____ Cancer: _____

Heart Disease: _____ Asthma: _____

Stroke: _____ Allergies: _____

High Blood Pressure: _____ Eczema: _____

Seizures: _____ Blood disorder: _____

Social History:
Please check beside any of the following you have used in the past or currently:

_____ Alcohol (beer, wine or spirits)
_____ Illegal Drugs
_____ Birth Control Pills
_____ Vitamins / Supplements
_____ Tobacco (cigarettes, cigar, pipe)
_____ Tobacco (chewing)
_____ Coffee
_____ Herbal Products

Medications:
List all of the Prescription Medicines or Over the Counter Drugs you are now taking:

_____

_____

Allergies:
Please list any medications to which you are allergic:

_____

Please list any foods that you are allergic or sensitive:

_____

Female:
Age menstruation began: _____
How frequent are periods: every _____ days How long do Periods usually last? _____ days Number of Pregnancies _____ Number of Births _____ Miscarriages _____ Abortions _____