



12710 STARKEY RD, LARGO, FL 33773-1426
Phone: (727) 624-0144 Fax: (877) 673-7472
Email: info@asedamc.com

New Patient Intake Form

Please complete your health questionnaire to the best of your ability.

Past Medical History

Please check off any of the following medical conditions you currently have or have had in the past:

- ☐ allergies
- ☐ anemia
- ☐ anxiety
- ☐ asthma
- ☐ blood or bleeding disorders
- ☐ cancer
- ☐ cardiovascular disease
- ☐ Chronic obstructive pulmonary disease
- ☐ chronic pain
- ☐ coronary artery disease
- ☐ depression
- ☐ gastrointestinal disorders
- ☐ high blood pressure
- ☐ high cholesterol
- ☐ HIV / AIDS
- ☐ kidney disease
- ☐ liver disease
- ☐ lung disease
- ☐ neurological disorders
- ☐ rheumatologic disorders
- ☐ thyroid disease
- ☐ type 1 diabetes
- ☐ type 2 diabetes



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Do you have any other disease, condition or problem not listed above that you feel we should know about? If so, Please explain:

If you currently have or have ever been diagnosed with cancer in the past, please list the type(s) of cancer here:

Have you had any surgery in the past? If yes, please describe:

Family History

Father (Please select all that apply):

- ☐ allergies
- ☐ asthma
- ☐ cancer
- ☐ cardiovascular disease
- ☐ gastrointestinal disorders
- ☐ high blood pressure
- ☐ kidney disease
- ☐ obesity
- ☐ psychiatric illness
- ☐ thyroid disease
- ☐ type 1 diabetes
- ☐ type 2 diabetes

Mother (Please select all that apply):

- ☐ allergies
- ☐ asthma
- ☐ cancer
- ☐ cardiovascular disease
- ☐ gastrointestinal disorders
- ☐ high blood pressure
- ☐ kidney disease
- ☐ obesity
- ☐ psychiatric illness
- ☐ thyroid disease
- ☐ type 1 diabetes
- ☐ type 2 diabetes



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Paternal Grandfather (Please select all that apply):

- ☐ allergies
- ☐ asthma
- ☐ cancer
- ☐ cardiovascular disease
- ☐ gastrointestinal disorders
- ☐ high blood pressure
- ☐ kidney disease
- ☐ obesity
- ☐ psychiatric illness
- ☐ thyroid disease
- ☐ type 1 diabetes
- ☐ type 2 diabetes

Paternal Grandmother (Please select all that apply):

- ☐ allergies
- ☐ asthma
- ☒ cancer
- ☐ cardiovascular disease
- ☐ gastrointestinal disorders
- ☐ high blood pressure
- ☐ kidney disease
- ☐ obesity
- ☐ psychiatric illness
- ☐ thyroid disease
- ☐ type 1 diabetes
- ☐ type 2 diabetes

Maternal Grandfather (Please select all that apply):

- ☐ allergies
- ☐ asthma
- ☐ cancer
- ☐ cardiovascular disease
- ☐ gastrointestinal disorders
- ☐ high blood pressure
- ☐ kidney disease
- ☐ obesity
- ☐ psychiatric illness
- ☐ thyroid disease
- ☐ type 1 diabetes
- ☐ type 2 diabetes

Maternal Grandmother (Please select all that apply):

- ☐ allergies
- ☐ asthma
- ☐ cancer
- ☐ cardiovascular disease
- ☐ gastrointestinal disorders
- ☐ high blood pressure
- ☐ kidney disease
- ☐ obesity
- ☐ psychiatric illness
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- ☐ type 2 diabetes



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Brother (Please select all that apply):

- ☐ allergies
- ☐ asthma
- ☐ cancer
- ☐ cardiovascular disease
- ☐ gastrointestinal disorders
- ☐ high blood pressure
- ☐ kidney disease
- ☐ obesity
- ☐ psychiatric illness
- ☐ thyroid disease
- ☐ type 1 diabetes
- ☐ type 2 diabetes

Sister (Please select all that apply):

- ☐ allergies
- ☐ asthma
- ☐ cancer
- ☐ cardiovascular disease
- ☐ gastrointestinal disorders
- ☐ high blood pressure
- ☐ kidney disease
- ☐ obesity
- ☐ psychiatric illness
- ☐ thyroid disease
- ☐ type 1 diabetes
- ☐ type 2 diabetes

Son (Please select all that apply):

- ☐ allergies
- ☐ asthma
- ☐ cancer
- ☐ cardiovascular disease
- ☐ gastrointestinal disorders
- ☐ high blood pressure
- ☐ kidney disease
- ☐ obesity
- ☐ psychiatric illness
- ☐ thyroid disease
- ☐ type 1 diabetes
- ☐ type 2 diabetes

Daughter (Please select all that apply):

- ☐ allergies
- ☐ asthma
- ☐ cancer
- ☐ cardiovascular disease
- ☐ gastrointestinal disorders
- ☐ high blood pressure
- ☐ kidney disease
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Household:

Marital Status:

- ☐ Single
- ☐ Married
- ☐ Widowed
- ☐ Divorced
- ☐ Not Answered

Occupation:

Tobacco Use/Smoking

Tobacco use:

- ☐ current smoker
- ☐ current every day smoker
- ☐ current some day smoker
- ☐ Smoker current status unknown
- ☐ former smoker
- ☐ nonsmoker
- ☐ unknown if ever smoked
- ☐ light tobacco smoker
- ☐ heavy tobacco smoker
- ☐ Uses tobacco in other forms

Alcohol Screen (Audit-C)

Did you have a drink containing alcohol in the past year?

- ☐ Yes ☐ No

Drugs

Have you used drugs other than those for medical reasons in the past 12 months?

- ☐ Yes ☐ No



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Caffeine

On average, how much caffeine do you consume each day?

- ☐ none
- ☐ 1-2 cups per day
- ☐ 2-3 cups per day
- ☐ 3-4 cups per day
- ☐ more than 4 cups per day

Miscellaneous:

How often do you exercise?

- ☐ none
- ☐ 1-2 times per week
- ☐ 3-4 times per week
- ☐ 5 or more times per week

General / Constitutional

Fatigue: ☐ Yes ☐ No

Fever: ☐ Yes ☐ No

Headache ☐ Yes ☐ No

Weight gain: ☐ Yes ☐ No

Weight loss: ☐ Yes ☐ No

Gastrointestinal

Nausea: ☐ Yes ☐ No

Vomiting: ☐ Yes ☐ No