

# Medical Patient Intake Assessment

## Personal Information

Full Name

Date of Birth

Gender

Phone

Email

Address

## Emergency Contact

Name

Phone

Relationship

## Medical History

Primary Physician

Current Medications

Allergies

Past Illnesses / Surgeries

Family Medical History

## Current Symptoms / Reason for Visit

Describe your current symptoms or reason for your visit

How long have you been experiencing these symptoms?

Severity (e.g. mild, moderate, severe)