HOPE&HELP®

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# PATIENT INTAKE FORM

UPDATED: 2/11/2021

**Todays' Date: ____ /____/____**

| YOUR INFORMATION | | | |
|---|---|---|---|
| **First Name (Legal):** | **Last Name (Legal):** | **MI:** | **DOB:**<br>**Social Security Number:** |
| **Preferred Name:** | **Sex or Gender (At birth):**<br>□ M □ F □ Decline | **Sex or Gender Identification:**<br>□ Male □ Female □ Non-Binary<br>□ Transwoman □ Transman □ Non-Conforming<br>□ Other □ Decline | |
| **Race/Ethnicity:**<br>□ Caucasian/White<br>□ African American/Black<br>□ Hispanic/Latino<br>□ Asian/Pacific Islander<br>□ Native American/American Indian<br>□ Two or more racial or ethnic groups<br>□ Other<br>□ Decline | **Sexual Orientation:**<br>□ Lesbian<br>□ Gay<br>□ Bisexual<br>□ Pansexual<br>□ Asexual<br>□ Heterosexual<br>□ Intersex<br>□ Other<br>□ Decline | **Preferred Language:**<br>□ English<br>□ Spanish<br>□ Haitian/Creole<br>□ Other<br>□ Decline | |
| **Address:** | **City:** | **State:** | **Zip Code:** |
| **Telephone:** | **Email:** | | |

| PHARMACY INFORMATION | | |
|---|---|---|
| **Pharmacy Name:** | **Address:** | **Telephone:**<br>**Fax:** |

| INSURANCE INFORMATION | |
|---|---|
| **Insurance Provider:** | **Plan Type:**<br>□ HMO □ PPO |
| **Policy or Member ID Number:** | **Group Number:** |
| **Policy Holder or Subscriber's Name:** | |

| EMERGENCY CONTACT | | | |
|---|---|---|---|
| **Name:** | **DOB:** | **Relationship:** | **Telephone:** |
| If patient is a minor, please provide parent or guardian information below. | | | |
| **Parent or Guardian Name:** | **DOB:** | **Address:** | **Telephone:** |

## MEDICAL HISTORY

**Current medical conditions (Check all that apply).**

□ High/Low Blood Pressure □ Diabetes □ High Cholesterol □ Depression □ Anxiety
□ Cancer □ GERD/Acid Reflux □ Asthma □ ADHD □ Heart Condition
□ Thyroid □ HIV □ AIDS □ Gout □ Arthritis
□ Anemia □ Seizures □ Other

**Prior infectious disease history (Check all that apply).**

Chlamydia: □ Genital □ Oral □ Anal Gonorrhea: □ Genital □ Oral □ Anal
Hepatitis: □ A □ B □ C Herpes: □ Oral □ Genital
□ Syphilis □ HPV □ Trichomoniasis

**If HIV positive, complete information below.**

HIV diagnosis date: _____ City and state of diagnosis: _____
Have you ever received an AIDS diagnosis? □ YES □ NO If yes, write AIDS diagnosis date: _____
Date of last T-cell (CD4) count: _____ Last known viral load date: _____
Current HIV medical care provider: _____
Are you currently case managed? □ YES □ NO If yes, write the name of agency: _____
Case Manager Name: _____

**Are you sexually active?**

□Yes □ No □ I have no sexual history

**With whom are you sexually active?**

□ Men □ Women □ Transmen □ Transwomen □ Other

**What is your sexual orientation?**

□ Heterosexual □ Homosexual □ Pansexual □ Bisexual □ Asexual

**What are your preferred pronouns?**

□ He, Him, His □ She, Her, Hers □ They, Them, Theirs □ Other
_____

List all the medications that you are currently taking.

| Medication | Dosage | Frequency | Prescriber |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

List any known allergies below.

| Allergy Source | Reaction | Treatment |
|---|---|---|
| | | |
| | | |

List all surgeries and hospitalizations below.

| Date | Medical Issue |
|---|---|
| | |
| | |
| | |
| | |

Indicate all immunizations and vaccinations below (Check all that apply).

□ FLU □ Tetanus □ Pneumovax 23 □ Adult Prevnar13 □ Zoster/Shingles
□ Twinrix (Hep A & B) □ Hep A □ Hep B □ HPV □ Other

## SUBSTANCE USE HISTORY

| | |
|---|---|
| Do you smoke or use cigarettes or tobacco?<br><br>□ YES □ NO | How frequently do you use cigarettes or tobacco?<br><br>□ Daily □ A few times a week |
| Are you a former smoker?<br><br>□ YES □ NO | Would you like help with quitting cigarettes or tobacco?<br><br>□ YES □ NO |
| Do you consume alcohol?<br><br>□ YES □ NO | How frequently do you consume alcohol?<br><br>□ Daily □ A few times a week |
| Do you use recreational drugs?<br><br>□ YES □ NO | What recreational drugs do you use?<br><br>□ Marijuana (frequency) _____<br>□ Cocaine (route)_____ (frequency) _____<br>□ Heroin (route) _____ (frequency) _____<br>□ Ecstasy (frequency) _____<br>□ PCP (frequency) _____<br>□ Amphetamines (frequency) _____<br>□ Others _____ |

## FAMILY MEDICAL HISTORY

□ No known family medical history □ Adopted □ High blood pressure □ Asthma □ Diabetes
□ Heart Condition □ High Cholesterol □ Mental illness □ Arthritis □ Cancer (Type)
_____
□ Stroke □Thyroid Condition □ Other _____

## CONSENT FOR DISCLOSURE

I agree that Hope & Help may disclose my medical information to me and the following individual(s) if I am not physically present, including disclosure by telephone, voicemail, facsimile, e-mail or regular mail. I agree to let certain individual(s) participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for Hope & Help and or staff to disclose my personal and my medical information to the following individual(s) indicated below. I also understand that this consent may be revoked by me at any time with written notice to Hope & Help.

_____ _____ _____
Name Date of Birth Relationship

_____ _____
Telephone Email

_____ _____ _____
Name Date of Birth Relationship

_____ _____
Telephone Email

_____ _____
Patient Signature Date

_____ _____
Parent or Guardian Signature Date
*(Required for patients 17 and younger)*