HYATT HEALTH

New Patient Intake Form

Name: _____ Date: _____

Phone Number: _____ Email: _____

Address: _____

Date of Birth: _____ Age: _____ Male/Female Height: _____ Weight: _____

Female Only: Pregnant Y / N LMP: _____ Hysterectomy: Y / N (if yes) Year: _____

Are you: Single Married Widowed Divorced Occupation: _____

Emergency Contact: _____ Phone Number: _____

Allergies to Medication: Y / N (if yes) List: _____

Are you taking any medication? Y / N (if yes) List: _____

Pharmacy Name: _____ Phone Number: _____

Primary Physician:_____ Phone Number:_____

Medical History: Y / N **Please circle all that apply**

Allergies	Blood Clots	Depression	Heart Condition	HIV	Seizures
Arthritis	Cancer	Diabetes	Hypertension	Lupus	Vertigo
Anxiety	Chronic Pain	Epilepsy	Hyperthyroid	Multiple Sclerosis	Any Other Condition:
Asthma	CHF	Hepatitis	Hypothyroid	Malnutrition	_____

Surgical History: Y / N _____

Do You smoke: Y/ N How much: _____Do you drink: Y / N How much: _____

How did you hear about us? _____

What services are you interested in?

Aesthetics Health Screenings IV Infusion Therapy Massage Wellness Shots Weight Loss