Woodinville Family Medicine & Dermatology

INTAKE

Date: _____ Name: _____ Date of Birth: _____

Please indicate your primary health concern: _____

_____

Smoking: ◯ Never ◯ Former smoker ◯ Current smoker

If current smoker, #/day: _____

Sleep (Hours/Day): _____

Exercise (Hours/Week): _____

Please list the medications and / or supplements you are currently taking:

_____

_____

_____

_____

_____

What is the name and address of the pharmacy you would like prescriptions sent to?

_____

_____

What is your occupation? _____

What is your highest completed level of education?

◯ Less than high school ◯ High school diploma or GED ◯ Some college ◯ Associate degree

◯ Bachelor's degree ◯ Master's degree ◯ Professional degree ◯ Doctorate