

GRACE CLINIC PATIENT INTAKE FORM

Patient Name: _____ Date of Visit: _____

MEDICAL PROFILE:

a. Chief Complaint:

b. History of Present Illness: (incl. location, how & when started, frequency & pattern, quality & severity, related signs & symptoms, treatment, impact)

c. Relevant PMH: (incl. chronic medical problems, current meds, family hist, drug allergies, hospitalizations, exposure to TB/AIDS/toxins, etc.)

d. System Review: (eg, weight change, fever, blood, cough, weakness, etc.)

e. Vital Signs:

Pulse: _____

BP: _____

Weight: _____

Temp: _____

PERSONAL PROFILE:

f. Grace Clinic Service Profile:

Veteran: Y N (to appraise for VA care eligibility)

-Discharge status, if known: _____

Smoker: Y (amt./freq. _____) N

Ability to pay for a Rx costing <\$20: Y N

g. Data Project Demographics:

Age: _____ Ethnicity: _____

Employed: Y N

Insurance: Y (type: _____) N

Don't know

OPTIONAL INFO:

h. Contact info: (only fill out for referrals or if other follow-up is likely)

Name of contact (if not same as patient): _____

Phone number: (_____) _____

Grace Drop-In Shelter: (608) 255-2960

(notes can be left on message board near dining area)

Hospitality House: (608) 255-4401

Safe Haven: (608) 241-9447

Best day / time to reach: _____

OR, Mailing Address:

Street: _____

Apartment/ PO Box: _____

City: _____

State: _____ Zip: _____

Hospitality House: 1490 Martin Street, Madison, WI 53713

OR, Email: _____

i. Previous clinic visits / hospitalization(s):

j. Previous doctor(s):

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PHYSICIAN ASSESSMENT:

Physical exam findings:

Assessment/Diagnoses:

Medications:

Drug / Gear (ie, socks)	Dosage	Quant.	Check one		Stamped Lot #	Exp. Date
			Rx	Sample		

Other Notes/Recommendations: (including referrals)

Staff signatures:

Student Name (print): _____ Physician Name (print): _____

Student Signature: _____ Physician Signature: _____