



Mason-Dixon Mobile Medicine

www.masondixonmed.com

☎240.397.6723 ☎949.655.2625

Time for a home visit?



PATIENT INTAKE FORM

Name: _____ Date: _____
 DOB: ___ / ___ / ___ Age: _____
 Sexual Orientation _____ Gender Identity _____
 Pronouns _____ Occupation _____
 Home Address _____
 Telephone (a) _____ (b) _____ Email _____
 Appointment reminders () telephone () text () email

Insurance Information

Primary	Secondary
Carrier _____	Carrier _____
Group _____	Group _____
Member ID _____	Member ID _____

Pharmacy Information

LOCAL Name: _____ City/State: _____
 MAIL-IN Name: _____ City/State: _____


Emergency Contact


Name: _____ Telephone (a) _____ (b) _____
 Relationship: _____ Email (a) _____ (b) _____

Address _____

202008028




 Lakeside Med, LLC
 3 Hillcrest Dr., Suite A-202
 Frederick, MD 21703-6270


 Lakeside Med, LLC
 7820B Wormans Mill Rd #276
 Frederick, MD 21701-3034





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Medical History

Allergies () none

() latex

() penicillins

() sulfa

() bees, etc.

() nuts

() other: _____

What type of reaction(s) do you have? _____

Current Medications

Name _____

Strength _____

Reason _____

How long _____

Rx by _____

Name _____

Strength _____

Reason _____

How long _____

Rx by _____

Name _____

Strength _____

Reason _____

How long _____

Rx by _____

Name _____

Strength _____

Reason _____

How long _____

Rx by _____

Gen Medical

() diabetes

() kidney disease

() pancreas

() liver disease

() thyroid disease

() arthritis

() Lyme



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Heart disease

- heart attack cholesterol stents bypass
- ↑ BP ASD / atrial septal defect
- heart failure

Lung disease

- asthma COPD TB COVID-19

Cancer

- breast colon ovary testicular
- Hodgkin's leukemia kidney pancreas
- prostate lung brain

Blood-borne

- Hep-B Hep-C HIV

Immune

- lupus RA

Psychiatric


- anxiety depression bipolar
- other: _____


Have you ever experienced a traumatic event? yes no

Neurological

- seizures neuropathy migraines MS
- Parkinson's head trauma stroke dementia




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Surgeries / Hospitalizations

Hospital _____
Dates _____
Reason _____

Hospital _____
Dates _____
Reason _____

Hospital _____
Dates _____
Reason _____

Hospital _____
Dates _____
Reason _____


Hospital _____
Dates _____
Reason _____


Hospital _____
Dates _____
Reason _____

Hospital _____
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Hospital _____
Dates _____
Reason _____




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Social History

Military Service () Army () Navy () Air Force () Marines

Rank _____ Length of service _____

Did you see conflict? () yes () no

Which conflict(s)? _____

Please describe any concerns you have related to your military service:

Marital/partner status

() single () married () partnered

() divorced () widowed

Education

() high school () some college () BA/BS () MA/MS

() doctorate

Occupation (current, former) _____


Tobacco use () never / none


() started age ____ () quit age ____

() cigarettes () ____ pk / day for ____ years

() cigar / pipe () smokeless




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Alcohol none

beer wine distilled

___ / day ___ / week ___ / month

___ social / holiday

Caffeine none

coffee/tea ___ cups / day soda ___ cans / day

Substance use none


marijuana cocaine heroin


other: _____

Have you ever injected illegal drugs, even once?

yes no




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