New Patient Intake Form

Welcome to The Health Index Medical Group.

Thank you for choosing us for your healthcare. This intake form helps our clinical team understand your current health, medical history, medications, lifestyle, and metabolic health goals so we can provide individualized, comprehensive care.

Please answer all questions as accurately as possible. If you are unsure of an answer, please indicate "Not Sure."

1. Patient Information

Legal Name

Preferred Name

Date of Birth

Age

Height

Current Weight

Preferred Pronouns

Sex Assigned at Birth:

☐ Female ☐ Male ☐ Prefer not to answer

Phone

Email

Preferred Method of Communication:

☐ Phone ☐ Text / SMS ☐ Email

Address

City

State

ZIP

Emergency Contact

Relationship

Phone

2. Reason for Today's Visit

What is your primary reason for establishing care with The Health Index Medical Group?

☐ Establish Direct Primary Care
☐ General Medical Care
☐ Metabolic Health / Weight Management
☐ Cholesterol Management
☐ Nutrition / Lifestyle Counseling

Other

What are your main health goals?

If seeking metabolic health / weight management, what would you most like to accomplish?

- ☐ Weight loss
- ☐ Weight maintenance
- ☐ Improve physical activity
- ☐ Reduce health risks
- ☐ Improve overall metabolic health

Other

3. Current Health Information

Height

Current Weight

Would you describe your diet as:

- ☐ Poor
- ☐ Fair
- ☐ Good

Is it food portion, food choices, both — and why?

How many days per week do you engage in intentional physical activity?

- ☐ 0
- ☐ 1–2
- ☐ 3–4
- ☐ 5 or more

Average minutes per session

4. Medical History

Have you ever been diagnosed with any of the following?

- ☐ High blood pressure / hypertension
- ☐ High cholesterol / dyslipidemia
- ☐ Prediabetes
- ☐ Type 1 diabetes
- ☐ Type 2 diabetes
- ☐ Cardiovascular / heart disease
- ☐ Heart failure
- ☐ Stroke / TIA
- ☐ Kidney disease
- ☐ Liver / fatty liver disease
- ☐ Thyroid disease
- ☐ Sleep apnea
- ☐ Asthma / COPD
- ☐ GERD / acid reflux
- ☐ Gallstones / gallbladder disease
- ☐ Polycystic ovary syndrome (PCOS)
- ☐ Depression / anxiety

Other

5. Metabolic Health & Medication Safety Screening

Thyroid Cancer History

Have you or your biological family ever been diagnosed with Medullary Thyroid Carcinoma (MTC)?

☐ No ☐ Yes ☐ Not sure

Medullary Thyroid Carcinoma (MTC) is a rare thyroid cancer from the thyroid's C-cells. A personal or family history of MTC is particularly important to report before treatment with certain GLP-1 / GIP-based medications.

Have you ever been diagnosed with Multiple Endocrine Neoplasia type 2 (MEN 2)?

☐ No ☐ Yes ☐ Not sure

If YES or NOT SURE to any thyroid question, please provide details if known

Pancreatitis History

Have you or your biological family ever had pancreatitis (inflammation of the pancreas)?

☐ No ☐ Yes ☐ Not sure

Pancreatitis is inflammation of the pancreas. It may cause significant or persistent upper abdominal pain, sometimes extending to the back, and may be associated with nausea or vomiting. A previous history is important when considering certain metabolic health medications.

If YES, please provide the approximate date and cause, if known

6. Other Metabolic Health Safety Questions

Have you ever had gallstones or gallbladder disease?

☐ No ☐ Yes ☐ Not sure

Have you ever had surgery to remove your gallbladder?

☐ No ☐ Yes

Have you ever had a serious allergic or adverse reaction to a medication?

☐ No ☐ Yes

If yes, please list the medication and reaction

Are you currently taking medication for diabetes or blood sugar control?

☐ No ☐ Yes

If yes, list medication(s)

Are you currently taking medication for weight management?

☐ No ☐ Yes

If yes, list medication(s)

Have you previously used a GLP-1 or GIP-based medication for weight management or diabetes?

☐ No ☐ Yes ☐ Not sure

If yes, please list the medication and your experience

7. Current Medications

Please list ALL prescription medications, over-the-counter medications, vitamins, and supplements you currently take.

Medication / Supplement	Dose	How Often	Reason

☐ I have no current medications or supplements.

8. Allergies

Do you have any medication, food, or environmental allergies?

☐ No known allergies ☐ Yes

Allergy

Reaction

Allergy

Reaction

9. Family History

Has a biological parent, sibling, or child had any of the following?

☐ Diabetes
☐ High blood pressure
☐ High cholesterol
☐ Heart disease
☐ Stroke
☐ Obesity / weight-related disease
☐ Thyroid disease
☐ Thyroid cancer
☐ Medullary thyroid carcinoma (MTC)
☐ Pancreatitis
☐ Kidney disease
☐ Liver disease

☐ Cancer

Other

10. Women's Health / Pregnancy

Are you currently pregnant and/or breastfeeding?

☐ No ☐ Yes ☐ Not sure ☐ Not applicable

Are you currently using contraception?

☐ No ☐ Yes ☐ Not applicable

Method, if applicable

11. Lifestyle & Wellness

Smoking / Nicotine:

☐ Never ☐ Former ☐ Current

Alcohol use:

☐ None ☐ Occasional ☐ Regular

How many hours of sleep do you typically get per night?

☐ Less than 5 ☐ 5–6 ☐ 7–8 or more

How would you describe your stress level?

☐ Low ☐ Moderate ☐ High

What is one health behavior you would most like help changing?

12. Preventive Health

When was your last physical examination?

Last blood work / lab testing

Are you up to date with recommended vaccinations?

☐ Yes ☐ No ☐ Not sure

13. Patient Health Goals

What are the top three health goals you would like to work on with your healthcare team?

Goal 1

Goal 2

Goal 3

What would make your care at The Health Index Medical Group successful for you?

14. Patient Acknowledgment

I certify that the information provided in this intake form is accurate and complete to the best of my knowledge. I understand that providing complete medical and medication history is important for safe and appropriate healthcare.

I understand that completion of this form does not guarantee that I will be prescribed any particular medication or treatment. Treatment decisions will be based on my medical history, examination, laboratory results when indicated, current medications, clinical assessment, and shared decision-making with my healthcare provider.

Electronic Signature

Patient Name

Date

Electronic Signature (type your full legal name to sign)