

## 2026 SEATTLE/KING COUNTY CLINIC PATIENT INTAKE RECORD

**PATIENT LABEL  
REQUIRED**

**PLACE PATIENT  
LABEL IN THIS BOX**

<b>PATIENT INTAKE</b>		Station:	Intake Provider:
Re-Check: <input type="checkbox"/> Y		Fever: <input type="checkbox"/> N <input type="checkbox"/> Y Temp if Y:	
HT:	WT:	BP (<180/110 - Dental):	
Pulse:		Gluc if Diabetic (<200 Dental):	
<b>SCREENING RESULTS</b>			
Active TB: <input type="checkbox"/> Neg <input type="checkbox"/> Pos		Respiratory: <input type="checkbox"/> Neg <input type="checkbox"/> Pos	Other: <input type="checkbox"/> Neg <input type="checkbox"/> Pos
<b>CURRENT RX</b>			
<input type="checkbox"/> NONE <input type="checkbox"/> Antibiotics <input type="checkbox"/> Antidepressants <input type="checkbox"/> Antihistamine <input type="checkbox"/> Bisphosphonates/denosumab  <input type="checkbox"/> OTHER:		<input type="checkbox"/> Blood thinners <input type="checkbox"/> Hormones <input type="checkbox"/> Immunosuppressants <input type="checkbox"/> Insulin/diabetic meds  <input type="checkbox"/> Prescription opioids <input type="checkbox"/> Psychiatric medication(s) <input type="checkbox"/> Statins <input type="checkbox"/> Steroids	

**ALLERGIES / DRUG INTOLERANCE**

- |                                  |   |   |                                 |
|----------------------------------|---|---|---------------------------------|
| <input type="checkbox"/> NONE    | <input type="checkbox"/> Clindamycin/erythromycin | <input type="checkbox"/> Latex                  | <input type="checkbox"/> Sulfa  |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine/narcotics        | <input type="checkbox"/> Penicillin/amoxicillin | <input type="checkbox"/> Other: |

**HEALTH HISTORY**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> NONE<br><input type="checkbox"/> Recent hospitalization<br><b>Cardio/Circulatory</b><br><input type="checkbox"/> Angina<br><input type="checkbox"/> Arrhythmia<br><input type="checkbox"/> Bleeding disorder<br><input type="checkbox"/> Heart attack yr: _____<br><input type="checkbox"/> Heart disease<br><input type="checkbox"/> Hypertension<br><b>Dental</b><br><input type="checkbox"/> Adverse dental RXN<br><input type="checkbox"/> Bisphosphonate/ever used<br><input type="checkbox"/> Dental anxiety<br><input type="checkbox"/> Oral cancer<br><b>Digestive/Excretory</b><br><input type="checkbox"/> Asplenia<br><input type="checkbox"/> Liver disease<br><input type="checkbox"/> Other: _____<br><b>Emotional/Behavioral Health</b><br><input type="checkbox"/> Anxiety/panic attacks<br><input type="checkbox"/> Behavioral concerns/disorders<br><input type="checkbox"/> Depression<br><input type="checkbox"/> Emotional concerns/disorders | <b>Endocrine</b><br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Thyroid<br><input type="checkbox"/> Other: _____<br><b>Infectious Disease</b><br><input type="checkbox"/> Active infectious disease<br>Type: _____<br>SX: <input type="checkbox"/> Respiratory illness<br><input type="checkbox"/> Gastrointestinal illness<br><input type="checkbox"/> Fever last 24 hours<br><input type="checkbox"/> Hepatitis A<br><input type="checkbox"/> Hepatitis B<br><input type="checkbox"/> Hepatitis C<br><input type="checkbox"/> HIV<br><input type="checkbox"/> MRSA<br><input type="checkbox"/> STI:<br><b>Muscular/Skeletal/Rheumatologic</b><br><input type="checkbox"/> Autoimmune disease:<br><input type="checkbox"/> Joint replacement<br><b>Nervous System</b><br><input type="checkbox"/> Seizures<br><input type="checkbox"/> Stroke<br><b>Reproductive</b><br><input type="checkbox"/> Breastfeeding (currently)<br><input type="checkbox"/> Pregnant | <b>Respiratory</b><br><input type="checkbox"/> Asthma<br><input type="checkbox"/> COPD<br><b>Substance Use</b><br><input type="checkbox"/> Alcohol<br><input type="checkbox"/> Cannabis<br><input type="checkbox"/> E-cigarettes/vaping<br><input type="checkbox"/> Tobacco<br><input type="checkbox"/> Intravenous drugs<br><input type="checkbox"/> Opioids/opiates<br><input type="checkbox"/> Other substances/drugs<br><input type="checkbox"/> Overdose history<br><b>Vaccinations</b><br><input type="checkbox"/> Hep A<br><input type="checkbox"/> Hep B<br><input type="checkbox"/> COVID-19<br><b>Vision</b><br><input type="checkbox"/> Cataracts<br><input type="checkbox"/> Conjunctivitis: current/recurrent<br><input type="checkbox"/> Glaucoma<br><input type="checkbox"/> Macular degeneration<br><b>Other</b><br><input type="checkbox"/> Radiation therapy: head/neck |
|---|--|---|

**OTHER NOTES:**