

**Dr. Rebecca Fournier - Family Practice
Adult (Age 19+) Patient Meet and Greet Form**

Patient Name: _____

Date of Birth: _____

Address: _____

Phone Number:
(H) _____ (W) _____ (C) _____

Medical History

Please list your previous and/or current medical conditions below.

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Please list any previous surgeries below.

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Medications

Please list any prescription medications, over the counter medications, and/or supplements that you take.

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Allergies

Please list any allergies that you have and the symptoms you experience.

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Family History

Please list any medical conditions that run in your family and the family member’s relationship to you (example: Heart attack – Father).

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____

Social History

Gender Identity: _____

Marital Status: _____

Children (Name and Age): _____

Employment: _____

Substance Use:

1. Do you smoke cigarettes or vape? If yes, please describe the type and frequency.

2. Do you consume alcohol? If yes, please describe the type and frequency.

3. Do you consume cannabis? If yes, please describe the type, method, and frequency.

Immunizations

Have you received any adult vaccinations such as Tdap, shingles, flu, pneumovax or prevnar? If yes, please list the vaccine below with the year you were vaccinated.

Expectations

What do you expect from your doctor/family medicine practice?

Thank you for completing this form.

