Melville H. Hughes, MD, PC

Due to new requirements from the United States Department of Health and Human Services, we are requesting that all patients complete our Supplemental Patient Intake Form. We realize that some of the questions may be redundant. We appreciate your patience and apologize for any inconvenience.

Today's Date_____

Patient's Name (PLEASE PRINT):_____

Date of Birth: _____/_____/_____ Sex: M ☐ F ☐

We are in the process of implementing a Patient Portal to provide a communication option for our patients in compliance with Health and Human Service Requirements. Please provide a valid email address below:

(REQUIRED)_____@_____

Ethnicity: ☐ Non-Hispanic ☐ Hispanic

Language Preference: ☐ English ☐ Spanish Other: _____

Race: ☐ Caucasian or European American ☐ African or African American ☐ Asian or Asian American
☐ Native American or Native Alaskan ☐ Native Hawaiian or Other Pacific Islander ☐ Other

Smoking Status:
☐ Not a current tobacco user
☐ 0 Cigarettes per day (non-smoker or less than 100 in lifetime)
☐ 0 Cigarettes per day (previous smoker)
☐ Current Tobacco User
Please select the option that best describes your tobacco use.
☐ Few (1-3) cigarettes per day
☐ Up to 1 pack per day
☐ 1-2 packs per day
☐ 2 or more packs per day

Do you take any prescription or non-prescription medications?

☐ No ☐ Yes (If yes please list)_____ Dosage(s): _____

_____Dosage(s):_____

_____Dosage(s):_____

Allergies to Medications?

☐ No ☐ Yes (If yes please list)_____

Location: ☐ Skin ☐ Local ☐ Abdominal ☐ Systemic/Anaphylactic

Describe your Reaction: _____

Severity: ☐ Very Mild ☐ Mild ☐ Moderate ☐ Severe

Please check if you have a history of the following:

☐ High Cholesterol	☐ Joint Replacement	☐ Cancer
☐ Depression	☐ High Blood Pressure	☐ Thyroid Condition
☐ Diabetes	☐ Skin Cancer	☐ Asthma

☐ Other_____

Signature:_____ Date: _____/_____/_____

(Parent or Guardian Signature if child is a minor)

Patient Phone Number _____

Pharmacy Name & Location _____ Pharmacy Phone Number ( ) _____-_____

(Please allow 24 hours for prescriptions to be filled. Thank You.)