Telehealth Patient Intake & Clinical Protocol Form

Clinic: Triangle Primary Care Associates
Visit Type: Telehealth (Video/Phone Consultation)

This multi■page form collects the patient’s medical history, telehealth consent, and detailed documentation required for remote evaluation under standard primary■care telehealth protocol.

1. Patient Information

Full Name: _____
Date of Birth (DD/MM/YYYY): _____
Gender: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone Number: _____
Email Address: _____

Emergency Contact
Name: _____
Relationship: _____
Phone: _____

Insurance Information
Insurance Provider: _____
Member ID: _____
Group Number: _____
Cardholder Name: _____
Relationship to Patient: _____

2. Medical History

Current Medical Conditions (check all that apply)
■ Hypertension ■ Diabetes ■ Asthma ■ COPD ■ Heart Disease
■ Kidney Disease ■ Thyroid Issues ■ Anxiety ■ Depression ■ Other: _____

Past Surgeries / Hospitalizations
1. _____
Year: _____Reason: _____

2. _____
Year: _____Reason: _____

Allergies
■ No known allergies ■ Allergies (list): _____

Medications (name, dose, frequency)
1. _____
2. _____
3. _____

Family History
Heart Disease: Yes/No Stroke: Yes/No Diabetes: Yes/No Cancer: Yes/No
Other: _____

3. Lifestyle / Social History
Tobacco Use: Yes/No Alcohol: None / Occasional / Frequent
Exercise Level: None / 1–2× weekly / 3+ weekly
Occupation: _____
Living Situation: _____

4. Reason for Telehealth Visit
Describe Symptoms: _____
Duration: _____
Home Treatment Tried: _____

5. Telehealth Clinical Protocol Requirements
• Provider must confirm patient identity visually or verbally.
• Patient must confirm they are in a private and safe location.
• Provider documents limitations of virtual exam and offers in■clinic follow■up if required.
• Provider must document vitals if patient can provide (weight, BP, HR, temp).
• All medical decisions follow primary care telehealth guidelines for safe prescribing.
• No controlled medication is prescribed without full evaluation, risk check, and follow■up plan.

Patient■Reported Vitals (if available)
Weight: _____ BP: _____ HR: _____ Temp: _____

6. Telehealth Consent & Acknowledgement

• I agree to receive medical consultation through video or phone.
• I understand that telehealth has limitations compared to in■person physical examination.
• I consent to electronic transmission of medical information securely.
• I understand I may be asked to follow up in person if needed.

Signature (or typed name): _____
Date: _____

7. Declaration
I confirm that all information provided is accurate to the best of my knowledge.

Patient Signature: _____
Date: _____

For Clinic Use Only (Provider Notes)

Initial Assessment: _____

Clinical Impressions: _____

Plan / Treatment / Follow■Up: _____

Provider Name: _____
Date & Time of Telehealth Visit: _____