

Telehealth Patient Intake & Clinical Protocol Form

Provider: Daniel Craviotto, MD

Visit Type: Telehealth (Video/Phone Consultation)

This multi-page form collects the patient's medical history, telehealth consent, and documentation required for remote evaluation under standard primary care protocols.

1. Patient Information

Full Name: _____

Date of Birth (MM/DD/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 | 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 / 1–2x 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.
- Patient must be in a private and safe location.
- Limitations of virtual exam must be explained.
- In-person follow-up may be required.
- Patient may provide vitals if available.
- All care follows standard clinical guidelines.
- No controlled medications without full evaluation and follow-up plan.

Patient-Reported Vitals (if available)

Weight: _____ BP: _____ HR: _____ Temp: _____

6. Telehealth Consent & Acknowledgement

- I agree to receive medical consultation via telehealth.
- I understand limitations compared to in-person exams.

- I consent to secure electronic transmission of information.
- I understand follow-up may be required.

Signature (or typed name): _____

Date: _____

7. Declaration

I confirm that all information provided is accurate.

Patient Signature: _____

Date: _____

For Provider Use Only

Initial Assessment: _____

Clinical Impressions: _____

Plan / Treatment / Follow-Up: _____

Provider Name: Daniel Craviotto, MD

Date & Time: _____