FOR OFFICE USE ONLY: H______ W______ BP______ P______ T______ O2______

New Patient Intake Form

Legal name: ________________________________ Preferred name (if different): ____________________________

Gender identity: ▢ Female ▢ Transgender woman ▢ Transgender man ▢ Genderqueer/gender non-binary ▢ Male ▢ Decline to state

What sex were you assigned at birth?: ▢ Female ▢ Male ▢ Decline to state

Preferred pronouns: ▢ He/Him ▢ She/Her ▢ They/Them ▢ Other______________

How did you hear about our practice? ▢ newspaper/magazine ad ▢ internet search ▢ insurance company ▢ word of mouth ▢ provider referral (Name of provider ______________________) ▢ other ________________

What is your native language? ▢ English ▢ Spanish ▢ Other: _____________

What is your race? ▢ American Indian/Alaska Native ▢ Asian ▢ Black or African American ▢ Native Hawaiian/Other Pacific Islander ▢ White ▢ Multiracial ▢ Prefer not to answer

What is your ethnicity? ▢ Hispanic ▢ Not Hispanic ▢ Prefer not to answer

What is the reason for your visit today?: ____

Primary Care Provider: __________________________ Specialists: _________________________________

Medications

List all current medications (dose and frequency):

1.______________________________________
2.______________________________________
3.______________________________________
4.______________________________________
5.______________________________________
6.______________________________________
7.______________________________________
8.______________________________________

List all current supplements:

1.______________________________________
2.______________________________________
3.______________________________________
4.______________________________________
5.______________________________________
6.______________________________________
7.______________________________________
8.______________________________________

Preferred Pharmacy: Name_____________________ Address: _____________________________________

List any drug allergies (including type of reaction): ▢ None _____________________________________

List dates of immunizations:

Hepatitis A ________ Flu shot __________ Tetanus/Tdap ________ HPV _______________

Hepatitis B ________ Pneumonia ________ Shingles ________

Social History:

Occupation:______________________________

Have you used tobacco products: ▢ Yes ▢ No

How many per day:________________________

Number of years:_______ Date quit:__________

Do you use drugs?: ▢ Yes ▢ No

What type of drugs?______________________

Place of employment:________________________

Do you drink alcohol? ▢ Yes ▢ No Type:________

How many drinks per week?__________________

History of alcohol abuse? ▢ Yes ▢ No

Have you ever felt the need to cut down? ▢ Yes ▢ No

Have you ever felt guilty about drinking? ▢ Yes ▢ No

Marital status: ☐ Single ☐ Married ☐ Domestic partner ☐ Separated ☐ Divorced ☐ Widowed
Who do you live with?____
If you have children, what are their ages?____
Do you exercise? What type and how often?____
Nutrition: Is there anything unique about your diet, including foods that you avoid:________________________
____

Do you have an advanced directive? ☐ Yes ☐ No

Do you have a Health care power of attorney ☐ Yes ☐ No Name: ______________________________

Past Medical History

Check the conditions that apply to you:

☐ Allergies
☐ Anemia
☐ Anxiety
☐ Asthma
☐ DVT
☐ Breast disease
☐ Depression
☐ Diabetes
☐ Eating disorder
☐ Endometriosis
☐ Fibroids of uterus
☐ Fibromyalgia
☐ Heart disease
☐ High blood pressure
☐ High cholesterol
☐ Irritable bowel syndrome
☐ Kidney stones
☐ Migraine
☐ Headaches
☐ Osteoporosis
☐ PCOS
☐ Reflux
☐ Hypothyroidism
☐ Hyperthyroidism

☐ Cancer- Type: ____
☐ Other:____
List any hospitalization or surgeries:____ ☐ None

Please list dates of screening tests if applicable:

Last pap smear:___________ ☐ Normal ☐ Abnormal __________________________________
Have you ever had an abnormal pap smear? ☐ Yes ☐ No Date: ___________________________
Explain:____
Last mammogram:________ History of abnormal mammogram? ☐ Yes ☐ No Date: ____________
Bone density:_____________ Results: ☐ Normal ☐ Osteopenia ☐ Osteoporosis
Colonoscopy:_____________ Results: ☐ Normal ☐ Abnormal ___________________________

Genetic History ☐ Adopted

Please list anyone genetically related to you who has a medical condition(s).

	High Blood Pressure	Diabetes	High Cholesterol	Heart Disease	Stroke	Breast Cancer	Ovarian Cancer	Colon Cancer	Osteoporosis	Mental Illness	Substance Abuse	Dementia	Thyroid Issues	Other
Mother														
Father														
Daughter														
Son														
Sister														
Brother														
Mat Grandmother														
Mat Grandfather														
Pat Grandmother														
Pat Grandfather														
Mat Aunt														
Mat Uncle														
Pat Aunt														
Pat Uncle														

Gynecologic history (if applicable):

Age when period started:________ Last menstrual period:_______________ ▢ Postmenopausal

Number of days between the first day of your period and the first day of your next period: _______________

Regular periods: ▢ Yes ▢ No Any recent changes in your periods?_________________________________

Number of pads/tampons used on heaviest day of flow:___ Menstrual cramps ▢ none ▢ mild ▢ mod ▢ severe

Pregnancy history (if applicable):

Total number of pregnancies:___ Number of living children:____ Number of ectopic pregnancies:___

Number of full-term births: ____ Number of adopted children:____ Number of abortions:____

Number of preterm births:____ Number of miscarriages:______

Sexual/relationship History:

Do you think of yourself as: ▢ Straight or heterosexual ▢ Lesbian, gay, or homosexual ▢ Bisexual

▢ Don't know ▢ Decline to answer

What do you use for birth control (if applicable): ▢ birth control pills ▢ condoms ▢ IUD

▢ Nexplanon/Implanon ▢ Nuvaring ▢ Depo-Provera ▢ Diaphragm ▢ tubal ligation ▢ vasectomy

History of sexually transmitted infections? ▢ Yes ▢ No Explain:______________________________________

Do you wish to be screened for sexually transmitted infections? ▢ Yes ▢ No

Have you been physically hurt by your partner or ex-partner? ▢ Yes ▢ No

Have you been emotionally abused by your partner or ex-partner? ▢ Yes ▢ No

Do you currently have any of the following symptoms? Please check all that apply.

General: ▢ Chills ▢ Fatigue ▢ Fever ▢ Night Sweats ▢ Weight Gain ▢ Weight loss

Eye/Ear/Nose/Throat: ▢ Ear Drainage ▢ Ear Pain ▢ Eye Discharge ▢ Eye Pain ▢ Hearing Loss

▢ Nasal Congestion ▢ Nasal Drainage ▢ Sinus Pressure ▢ Sneezing ▢ Sore Throat

▢ Itchy Eyes ▢ Visual Changes

Respiratory: ▢ Cough ▢ Shortness of Breath ▢ Wheezing

Cardiovascular: ▢ Chest Pain ▢ Edema ▢ Palpitations

Gastrointestinal: ▢ Abdominal Pain ▢ Constipation ▢ Diarrhea ▢ Heartburn ▢ Loss of Appetite ▢ Nausea

▢ Vomiting

Genitourinary & Reproductive: ▢ Dysuria ▢ Blood in Urine ▢ Awakening at Night to Urinate

▢ Urinary Frequency ▢ Urinary Incontinence ▢ Burning with Urination ▢ Lack of Periods ▢ Painful Periods

▢ Heavy Periods ▢ Irregular Periods ▢ Low Libido ▢ Pain with Sex ▢ Hot Flashes ▢ Vaginal Discharge

▢ Vaginal Dryness

Breast: ▢ Nipple Discharge ▢ Lumps ▢ Breast Pain

Dermatologic: ▢ Excessive Hair ▢ Hives ▢ Itching ▢ Changes in Moles ▢ Rash ▢ Skin Lesion

Neurological: ▢ Dizziness ▢ Numbness ▢ Weakness ▢ Gait Disturbance ▢ Headache ▢ Memory Loss

▢ Loss of Consciousness ▢ Seizures ▢ Tingling ▢ Tremors

Mental Health: ▢ Anxiety ▢ Depression ▢ Insomnia ▢ Suicidal Thoughts

Endocrine: ▢ Cold Intolerance ▢ Heat Intolerance ▢ Excessive Thirst

Musculoskeletal: ▢ Back Pain ▢ Joint Pain ▢ Joint Swelling ▢ Muscle Weakness ▢ Neck Pain ▢ Muscle Aches

Hematologic: ▢ Easy Bleeding ▢ Easy Bruising

Allergies: ▢ Contact Allergies ▢ Environmental Allergies ▢ Food Allergies ▢ Seasonal Allergies

Depression screening:

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Eating disorder screening:

Are you satisfied with your eating patterns? ▢ Yes ▢ No

Do you ever eat in secret? ▢ Yes ▢ No

Does your weight affect the way you feel about yourself? ▢ Yes ▢ No

Have any members of your family suffered with an eating disorder? ▢ Yes ▢ No

Do you currently suffer with or have you ever suffered in the past with an eating disorder? ▢ Yes ▢ No