



### 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  social media  event  
 word of mouth  provider referral (Name of provider \_\_\_\_\_)  insurance company

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 \_\_\_\_\_  
Hepatitis B \_\_\_\_\_ Pneumonia \_\_\_\_\_

Tetanus/Tdap \_\_\_\_\_ HPV \_\_\_\_\_  
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



**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  
Queer 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