



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

Pronouns: He/Him She/Her They/Them Other _____

What is the reason for your visit today?: annual exam Other _____

Primary Care Provider: _____ Specialists: _____

List all medications:	Refill needed?		Refill needed?
1. _____	<input type="checkbox"/>	5. _____	<input type="checkbox"/>
2. _____	<input type="checkbox"/>	6. _____	<input type="checkbox"/>
3. _____	<input type="checkbox"/>	7. _____	<input type="checkbox"/>
4. _____	<input type="checkbox"/>	8. _____	<input type="checkbox"/>

List all current supplements:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

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: _____	Place of employment: _____
Have you used tobacco products: <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____
How many per day: _____	How many drinks per week? _____
Number of years: _____ Date quit: _____	History of alcohol abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever felt the need to cut down? <input type="checkbox"/> Yes <input type="checkbox"/> No
What type of drugs? _____	Have you ever felt guilty about drinking? <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____

New medical problems, surgeries, and injuries since last visit: _____

Preventive Care: Please list dates of screening tests if applicable.

Last pap smear: _____ Normal Abnormal _____

Last mammogram: _____ History of abnormal mammogram? Yes No Results: _____

Bone density test: _____ Results: Normal Osteopenia Osteoporosis

Colonoscopy : _____ Results: Normal Polyps Abnormal _____

Family History:

List any changes in your family medical history since your last visit: _____

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