FOR OFFICE USE ONLY: H	W	BP	Р	Т	O2	
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New Patient Intake Form

Legal name:	Preferred name (if different):
What is your gender identity? Female Transgender	der woman ☐Transgender man ☐Genderqueer/Non-binary
☐Male ☐Decline to state	
What sex were you assigned at birth? Female N	Male Intersex Decline to state
What pronouns do you use? He/Him She/Her	☐They/Them ☐ Ze/Hir ☐Other
How did you hear about our practice? newspape	er/magazine ad internet search social media event
	der)
What is your native language?	
What is your race? American Indian/Alaska Native	
Native Hawaiian/Other Pacific Islander White	
What is your ethnicity? Hispanic Not Hispanic	
Primary Care Provider:	Specialists:
Medications List all current medications (dose and	
frequency):	List all current supplements:
1	1
2 3	2 3
4	4
5	5
6	6
7	7
8	8
Dueferred Dharman, North	Address
-	Address:
List any drug anergies (including type of reaction).	
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: Yes No	Do you drink alcohol? OYes No Type:
How many per day:	How many drinks per week?
Number of years: Date quit:	History of alcohol abuse? ☐Yes ☐No
Do you use drugs?: □Yes □No	Have you ever felt the need to cut down? Yes No
What type of drugs?	Have you ever felt guilty about drinking? ☐Yes ☐No

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Who do you live with?			
	_		
Numion. Is there anything	unique about your diet, includin	ng foods that you avoid:	
Do you have an advanced	directive? OYes No		
Do you have a Health care	power of attorney OYes ONo	Name:	
	Doof Mo	die al History	
Check the conditions tha		edical History	
□Allergies	Depression	☐High blood pressure	Osteoporosis
□Anemia	Diabetes	☐High cholesterol	□PCOS
Anxiety	☐Eating disorder	☐Irritable bowel	□Reflux
☐Asthma	· ·	syndrome	
	Endometriosis	☐Kidney stones	Hypothyroidism
□DVT	☐Fibroids of uterus	_	☐Hyperthyroidism
☐Breast disease	□Fibromyalgia	☐Migraine	
	☐Heart disease	Headaches	
☐Cancer- Type:			
Other:			
			□None
Have you ever had an		al ⊇No Date:	
Last mammogram:	History of abnormal m	nammogram?	
Bone density:	Results: Normal	Osteopenia Osteoporosis	
Colonoscopy:		Abnormal	
enetic History)Adopted		
Please list anyone genetica	ally related to you who has a me	edical condition(s).	
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Blood	State of High Chales and State Best State	did osedo de lines le partir	ad 15th
High	jates light rest store store out	dold ofe Neri Sips deril	throid 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: OYes ONo Any recent changes in your periods?
Number of pads/tampons used on heaviest day of flow: Menstrual cramps \(\subseteq \text{none} \subseteq \text{mild} \subseteq \text{mod} \subseteq \text{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 identify as: □Straight or heterosexual □Lesbian, gay, or homosexual □Bisexual
☐ Pansexual ☐ Queer ☐ Don't know ☐ Decline to answer
What do you use for birth control (if applicable): birth control pills condoms IUD Diaphragm Nuvaring
○ Nexplanon/Implanon ○ Depo-Provera ○ tubal ligation ○ vasectomy ○ Other
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 □Runny Nose □Sinus Pressure □Sneezing □Sore Throat
□ltchy 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: Painful Urination 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

PHQ:

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