

	P
	M
	C
	D
	Lab
	Ref

New Patient Form

Name: _____ Date of birth: _____ Age: _____

Primary care provider: _____ Specialists: _____

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? _____

Sexual history:

Are you sexually active? Yes No

If sexually active, are you active with: 1 partner multiple partners men women men and women

What do you use for birth control? birth control pills condoms IUD tubal NuvaRing
 implant vasectomy diaphragm Depo-Provera Nothing

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

Preferred pharmacy: name _____ location _____

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. _____

Are you allergic to any medications? Yes No

Specify any allergies: _____

Vaccination history:

Flu shot _____ Tetanus/Tdap _____ Pneumonia _____ Shingles _____

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

Do you have any of the following symptoms at this time? Please check all that apply.

General

- Hot flashes
- Night sweats
- Unusual fatigue

Gastrointestinal

- Abdominal pain
- Constipation
- Diarrhea
- Heartburn
- Nausea and vomiting

Breast

- Breast pain
- Breast lumps
- Nipple discharge

Metabolic/endocrine

- Cold intolerance
- Heat intolerance
- Excessive thirst

Eye/ear/nose/throat

- Hearing loss
- Sinus pressure

Genitourinary

- Blood in urine
- Urinary incontinence

Dermatologic

- Rash
- Changes in moles

Musculoskeletal

- Joint pain
- Joint swelling

Respiratory

- Cough
- Shortness of breath
- Wheezing

Reproductive

- Vaginal dryness
- Pain with sex
- Low libido
- Vaginal discharge
- Irregular periods
- Heavy periods
- Menstrual cramps

Neurological

- Headaches
- Seizures
- Memory loss

Hematologic

- Easy bleeding
- Easy bruising
- Enlarged lymph nodes

Cardiovascular

- Chest pain
- Heart palpitations
- Swelling of legs

Mental health

- Anxiety
- Depression
- Insomnia
- Suicidal thoughts

Immunologic

- Environmental allergies
- Food allergies

Social history

Do you currently use tobacco products? Yes No

Have you **ever** used tobacco products? Yes No

If yes, specify type of tobacco: _____ Number of years of use _____ Age when quit _____

Do you drink alcohol? Yes No

Type of alcohol: beer wine liquor

Number of 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

Do you use recreational drugs? Yes No If yes, please list type(s): _____

Marital status: Single Married Domestic partner Separated Divorced Widowed

Who do you live with? _____

Do you exercise? What type and how often? _____

Nutrition: Briefly describe your diet _____ Vegetarian Vegan

Occupation: _____ Place of employment: _____

Pregnancy history:

Number of full-term deliveries: _____ Number of pre-term deliveries: _____

Number of vaginal deliveries: _____ Number of cesarean sections: _____

Number of miscarriages: _____ Number of abortions: _____ Number of living children: _____

Gynecologic history:

Age when period started: _____ Last menstrual period: _____ **OR** Age at menopause _____

If having periods, please state the number of days between the first day of your period and the first day of your next period: _____

Irregular periods: Yes No Any recent changes in your periods? _____

Number of pads/tampons used on heaviest day of flow: _____

Menstrual cramps: none mild moderate severe

Check all conditions that apply to you:

- Allergies
- Anemia
- Anxiety
- Asthma
- Breast disease
- Cancer
- Depression
- Diabetes
- DVT
- Eating disorder
- Endometriosis
- Fibroids of uterus
- Fibromyalgia
- Heart disease
- High blood pressure
- High cholesterol
- Irritable bowel syndrome
- Kidney stones
- Migraine headaches
- Osteoporosis
- PCOS
- Reflux
- Thyroid problems

Other _____

List any hospitalization or surgeries: None _____

Screening tests:

Last pap smear: _____ Normal Abnormal _____
 Have you ever had an abnormal pap smear? Yes No
 Explain: _____
 Last mammogram: _____ History of abnormal mammogram? Yes No _____
 Bone density: _____ Results: Normal Osteopenia Osteoporosis
 Colonoscopy: _____ Results: Normal Abnormal _____

Family history:

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

How did you hear about this practice? internet search word of mouth provider referral insurance company