New Patient Form

Name: _____ Date of birth: _____ Age: _____

Name of family medicine or internal medicine practice: _____

Native language: ☐ English ☐ Spanish ☐ Other (please specify) _____

Race? ☐Native American/Alaska Native ☐Asian ☐Black ☐Native Hawaiian/Other Pacific Islander ☐ White ☐ Multiracial ☐ Prefer not to answer

Ethnicity ☐ Non-Hispanic ☐ Hispanic ☐ Prefer not to answer

Reason for visit: _____

Preferred pharmacy and location: _____

Current symptoms: Please place a check mark in the appropriate box.

Current symptoms	**None**	**Mild**	**Moderate**	**Severe**
Hot flashes				
Heat intolerance				
Sleep problems				
Depressed mood				
Irritability				
Anxiety				
Fatigue				
Sexual problems/decreased libido				
Bladder problems				
Vaginal dryness/pain with intercourse				
Joint and muscular symptoms				
Difficulties with memory				
Problems with thinking, concentrating, or reasoning				
Difficulty learning new things				
Word loss				
Increased in frequency or intensity of headaches				
Hair loss, change in hair texture				
Cold intolerance				
Weight gain, difficulty losing weight				
Dry or wrinkled skin				

Medications (dose and frequency)	**Supplements**
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.

List any medication allergies: _____

_____

Over the past 2 weeks, how often have you had 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

Sexual history:

Are you sexually active? □ Yes □ No

If yes: □1 partner □ multiple partners □ men □ women □ men and women

Method of birth control:

☐ Menopause □ tubal ligation □ vasectomy ☐ birth control pills □ IUD ☐ Nothing

Any history of intimate partner violence: ☐ Yes ☐ No ☐ Partner ☐ Ex-partner

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

Social history:

Do you use tobacco products? ☐ Yes ☐No
Do you drink alcohol? ☐ Yes ☐No If yes, number of drinks per week: _____
History of alcohol abuse? ☐ Yes ☐No
Do you use recreational drugs? ☐ Yes ☐No If yes, please specify: _____

Marital status:

☐ Single ☐ Married ☐ Domestic partner ☐ Separated ☐ Divorced ☐Widowed
Who do you live with? _____
Exercise type: _____ Exercise frequency: _____
Occupation: _____ Employer: _____

Pregnancy history:

Full term pregnancies _____ # Pre-term pregnancies _____
Vaginal deliveries _____ # Cesarean deliveries _____
Living children _____ # Miscarriages _____ #Abortions _____

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

Number of days from first day of one menstrual period to the first day of the next menstrual period: _____

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

Menstrual cramps: ☐ None ☐ Mild ☐ Moderate ☐ Severe

Check all conditions that you HAVE RIGHT NOW:

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

Other illness not listed above: _____

Have you had a blood clot in your lungs or legs? ☐ Yes ☐No

List any hospitalizations or surgeries: _____

Last Pap smear: _____ ☐ Normal ☐ Abnormal

Last mammogram: _____ ☐ Normal ☐ Abnormal

Bone density scan: _____ ☐ Normal ☐ Abnormal

Colonoscopy: _____ ☐ Normal ☐ Abnormal

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