Chapel Hill Gynecology/Hormone Therapy

New Patient Form

	Mg
	Dx
	Lab
	Ref

Name:_____Date of birth:_____Age: _____

Primary care doctor:_____Specialists:_____

Preferred pharmacy: _____ location _____

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? _____

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? _____

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

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: _____

_____

Over the past 2 weeks, circle 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

Have you had any of the following symptoms in the last two weeks? Please check all that apply.

General
□ Hot flashes
□ Night sweats
□ Unusual fatigue

Eye/ear/nose/throat
□ Hearing loss

Respiratory
□ Shortness of breath

Cardiovascular
□ Chest pain
□ Heart palpitations

Gastrointestinal
□ Abdominal pain
□ Constipation
□ Diarrhea
□ Heartburn

Genitourinary
□ Urinary incontinence

Reproductive
□ Vaginal dryness
□ Pain with sex
□ Low libido
□ Menstrual cramps
□ Irregular periods
□ Heavy periods

Breast
□ Breast pain
□ Breast lumps
□ Nipple discharge

Dermatologic
□ Rash
□ Changes in moles

Neurological
□ Headaches
□ Memory problems

Mental health
□ Anxiety
□ Depression
□ Insomnia
□ Suicidal thoughts

Metabolic/endocrine
□ Cold intolerance
□ Heat intolerance

Musculoskeletal
□ Joint pain
□ Joint swelling

Hematologic
□ Enlarged lymph nodes

Immunologic
□ Environmental allergies
□ Food allergies

Social history
Do you use tobacco now? □ Yes □ No
Have you used tobacco in the past? □ Yes □ No
If yes, specify type of tobacco: _____ Number of years of use_____ Age when quit _____
Do you drink alcohol? □ Yes □ No
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:
# of full-term deliveries: _____ # of pre-term deliveries: _____
# of vaginal deliveries: _____ # of cesarean deliveries: _____
# of miscarriages: _____ # of abortions:_____ # children living: _____

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 a 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	☐ 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_____

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