**Date: _____** **Appointment time: _____**

# New Patient Intake Form

Name: _____ Preferred Name: _____ Pronouns used: _____

Age: _____ Occupation: _____ Relationship Status: _____

How did you hear about us? _____

Reason for visit (circle): **Routine/Well Visit** **Problem Visit**

Issues you would like to discuss: _____

Would you like testing for sexually transmitted infections? *Yes* *No* Flu Vaccine? *Yes* *No*

Current medications, contraceptives & supplements (with doses, if known): ☐ *No current meds*

_____

Medication & food allergies (with reactions, if known): ☐ *No known allergies*

_____

**Gynecological & Sexual History:**

**First day of last menstrual period:** _____ Age of last period (if postmenopausal/hysterectomy): _____

Age of first period: _____ # days from one period to the next: _____ # days you bleed: _____

Any problems with your period: _____

**Date of last pap smear:** _____ **Results of last pap:** _____

Have you ever had an abnormal pap? *yes* *no* If yes, when: _____

Was any treatment needed (colposcopy, LEEP/Cone, cryotherapy): _____

Have you ever been diagnosed with/treated for any of the following (please circle):

| | | |
|---|---|---|
| HPV | Syphilis | Ovarian cysts |
| Genital warts | Vaginitis | Endometriosis |
| Genital herpes | Trichomonas | PCOS |
| Chlamydia | HIV | PID |
| Gonorrhea | Fibroids | Other: _____ |

Are you sexually active: *yes* *not currently* *not ever* Are you currently monogamous: *yes* *no*

Do you have sex with: *male partner(s)* *female partner(s)* *FTM partner(s)* *MTF partner(s)*

**Current birth control method**, with initiation date: _____

Birth control methods used in past, and any problems: _____

**Obstetrical History:** (Please complete chart below for all deliveries):

#pregs: ____ #full-term: ____ #pre-term: ____ #miscarriages: ____ #abortions: ____ #ectopic: ____ #living children: ____ #adopted: ____

| No | Birth Date | Birth Weight | Baby's Sex | Weeks Pregnant | Type of Delivery (vag, forceps/vacuum, c/s) | Complications |
|---|---|---|---|---|---|---|
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |

**Personal & Family Medical History:** ☐ *I have no knowledge of my family history*

| | Self | Mother | Father | Sister(s) | Brother(s) | Moms Mom | Dads Mom | Moms Dad | Dads Dad | Mat Aunt(s) | Pat Aunt(s) | *Please Specify:* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alive "A", or Deceased "D" | X | | | | | | | | | | | |
| If deceased, ~age at death | X | | | | | | | | | | | |
| Autoimmune disease | | | | | | | | | | | | |
| Bleeding/Clotting problems | | | | | | | | | | | | |
| Cancer (what type, age at dx) | | | | | | | | | | | | |
| Diabetes | | | | | | | | | | | | |
| High Blood Pressure/Heart dz | | | | | | | | | | | | |
| Mental Health Conditions | | | | | | | | | | | | |
| Migraine (with aura?) | | | | | | | | | | | | |
| Thyroid Disease | | | | | | | | | | | | |
| Other: | | | | | | | | | | | | |

**Surgeries & Hospitalizations:** (with approximate year):

_____ _____

_____ _____

**Health Maintenance & Prevention:**

Have you completed the Gardasil Vaccine series (HPV vaccine)? *yes* *no* *incomplete*

Do you exercise regularly: *yes* *no* Smoke tobacco: *yes* *no* *in past*

Other substances: _____

How many days per week do you drink alcohol: _____ How many drinks at a time: _____

Most recent Mammogram, with results: _____

Colonoscopy: _____ Bone Density: _____

***We are concerned about your safety and we ask all of our patients about the presence of violence/abuse in their daily life:***

Do you feel safe in your relationship: *yes* *no* Have you been sexually abused, threatened or hurt by anyone: *yes* *no*