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*