NEW PATIENT INTAKE FORM

Name: ______________________________________ __________ ______/______/______
(First) (Last) (Age) (Date of birth)

Preferred name (if different than above): ____________________________

Gender: ☐ Female ☐ Male ☐ FTM ☐ MTF ☐ Other:____________________

Health Concerns / Symptom Scale:

Please list your most important health concerns and/or symptoms. We will revisit this scale at each subsequent visit to monitor the effectiveness of your treatment plan.

Health concern (1): ____

Symptoms:____

____

____

Severity scale: 1 mild 2 3 4 5 6 7 8 9 10 severe

Health concern (2):____

Symptoms:____

____

____

Severity scale: 1 mild 2 3 4 5 6 7 8 9 10 severe

Health concern (3): ____

Symptoms: ____

____

____

Severity scale: 1 mild 2 3 4 5 6 7 8 9 10 severe

Medical History:

If you have a primary care physician, please provide his/her name, address and phone #:

____
____
____

Please list all current **prescription medications**, including dose:

____
____
____
____
____

Please list all current **supplements and over the counter medications**, including dose:

____
____
____
____
____

List any significant prior illnesses / conditions which you have been diagnosed with, including the date (ie. hypertension, February 2015):

____
____
____
____

List all surgeries, hospitalizations and significant injuries, including the date (ie. tonsillectomy, October 1991):

____
____
____
____

List any major accidents or illnesses during childhood not already indicated:

____
____
____

Exams and Imaging:

Date of last physical exam? _____________

Date of last blood work? ________________

Please indicate if you have ever had any of the following imaging studies:

▢ X-ray
Date:___________________________
Reason:_________________________
Result:_________________________

▢ MRI
Date:___________________________
Reason:_________________________
Result:_________________________

▢ CAT scan
Date:___________________________
Reason:_________________________
Result:_________________________

▢ Ultrasound
Date:___________________________
Reason:_________________________
Result:_________________________

▢ Other:___________________________
Date:___________________________
Reason:_________________________
Result:_________________________

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Allergies:

Please list any allergies to foods or medications, including reaction:

____
____
____
____

Do you experience seasonal allergies?
▢ Yes ▢ No

Do you experience environmental allergies?
▢ Yes ▢ No
Explain:______________________________

Vaccination History:

Indicate if you have been immunized (I), had the disease (D), neither (N), or unknown (U).

	I	D	N	U
Tetanus				
Pertussis				
HiB				
Measles				
Mumps				
Rubella				
Chicken Pox				
Shingles				
HPV				
PCV				
Polio				
Meningococcal				
Pneumonia				
Annual Influenza				
Other (please list):				

Have you had any adverse reactions to vaccinations? ▢ Yes ▢ No
Explain:______________________________

Social History:

What is your current job?________________
What are your hobbies?________________

Occupational Concerns – indicate if your work exposes you to any of the following:

Exposure	Yes	No	Frequency
Stress			
Toxic/hazardous substances			
Heavy lifting			
Prolonged sitting			
Other:			

Foreign Travel – Have you traveled outside of the United States in the past year?
▢ Yes ▢ No Where:________________

Exercise – Do you exercise regularly?
▢ Yes ▢ No
Indicate the type of activity and the frequency:____________________________
____
____

Energy – Rate your regular energy levels on a scale of 1-10, 10 being most:_____________

Sleep:
How many hours do you usually sleep per night?_____________
Do you wake feeling well-rested?
▢ Yes ▢ No

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Indicate if you experience the following:
- ▢ Difficulty falling asleep
- ▢ Difficulty staying asleep
- ▢ Waking often to urinate
- ▢ Snoring
- ▢ Grinding teeth
- ▢ Nightmares
- ▢ Sleepwalking
- ▢ Sleep apnea
- ▢ Waking due to pain
- ▢ Do you use any sleep-aids?____________

Health Habits:
Do you drink alcohol?
▢ Daily ▢ Weekly ▢ Monthly ▢ No
If yes, indicate how many drinks per occasion:_____________________________

Do you smoke or use tobacco products?
▢ Yes ▢ No ▢ In the past
If yes, indicate for how long and how many packs per day:_________________________

Do you use any recreational drugs?
▢ Yes ▢ No ▢ In the past
If yes, indicate what type and how often:
____

Do you drink caffeine?
▢ Yes ▢ No
If yes, indicate what type and how many cups per day:__________________________

Diet:
Do you follow a specific diet?
▢ Yes ▢ No Explain:_________________
How many meals do you eat per day?______
How many ounces of water do you drink per day?_______

Relationships:
Please indicate your relationship status:
- ▢ Single
- ▢ Married
- ▢ Domestic partnership/Civil union
- ▢ Partnered
- ▢ Involved with multiple partners
- ▢ Divorced/separated from spouse/partner
- ▢ Other: _____________________________

Living Situation:
- ▢ Live alone
- ▢ Live with spouse/partner
- ▢ Live with roommate(s)
- ▢ Live with parents or other family
- ▢ Other:______________________________

Children in Home:
- ▢ No children in home
- ▢ My own children live with me/us
- ▢ My spouse's/partner's children live with me/us
- ▢ Shared custody with ex-spouse/partner

Stress - Rate your average stress levels on a scale of 1-10, 10 being most:___________

What are your major sources of stress?
▢ Job ▢ Loss
▢ School ▢ Finances
▢ Relationship ▢ Health
▢ Family/children ▢ Other: __________

How would you rate your current support system?
▢ Strong ▢ Moderate ▢ Limited

Do you have a history of abuse?
- ▢ Mental abuse
- ▢ Emotional abuse
- ▢ Physical abuse
- ▢ Sexual abuse
- ▢ Other:_______________________________

If yes, by whom and at what age?_________
____

Family History:

Has any blood relative ever been diagnosed with the following conditions? Indicate which relative (maternal aunt, paternal grandmother, father, son, etc.) next to the condition below:

- ☐ Cancer:____________________________
- ☐ Asthma:____________________________
- ☐ Allergies:__________________________
- ☐ Diabetes:___________________________
- ☐ Heart attack:_______________________
- ☐ Stroke/TIA:_________________________
- ☐ High blood pressure:_________________
- ☐ Heart disease:______________________
- ☐ Celiac disease:_____________________
- ☐ Sickle cell anemia:___________________
- ☐ Thyroid disorder:____________________
- ☐ COPD/emphysema:___________________
- ☐ Autoimmune disease:________________
- ☐ Osteoporosis:_______________________
- ☐ Rheumatoid arthritis:_________________
- ☐ Tuberculosis:_______________________
- ☐ Mental illness: ______________________
- ☐ Other:_____________________________

Review of Systems:

Please indicate if you currently experience any of the following symptoms:

General:
- ☐ weight change
- ☐ appetite change
- ☐ fever/chills
- ☐ weakness
- ☐ fatigue
- ☐ night sweats

Eyes:
- ☐ dryness
- ☐ watery eyes
- ☐ itching eyes
- ☐ red eyes
- ☐ eye strain
- ☐ cataracts
- ☐ stye
- ☐ dark circles
- ☐ eye discharge
- ☐ vision problems
- ☐ glaucoma
- ☐ macular degeneration

Ears/Nose/Throat:
- ☐ ringing
- ☐ hearing changes
- ☐ ear discharge
- ☐ ear pain
- ☐ vertigo
- ☐ nose bleeds
- ☐ polyps
- ☐ problems smelling
- ☐ post-nasal drip
- ☐ nasal congestion
- ☐ nasal discharge
- ☐ sinusitis
- ☐ sore throat
- ☐ hoarseness
- ☐ gum disease
- ☐ mouth sores
- ☐ problems swallowing
- ☐ goiter
- ☐ neck stiffness
- ☐ problems tasting

Cardiovascular:
- ☐ murmur
- ☐ palpitations
- ☐ congestive heart failure
- ☐ blue hands/feet
- ☐ rheumatic fever
- ☐ arrhythmia
- ☐ angina
- ☐ chest pain
- ☐ low blood pressure
- ☐ high blood pressure
- ☐ varicose veins
- ☐ edema/swelling

Respiratory:
- ☐ asthma
- ☐ bronchitis
- ☐ cough
- ☐ wheezing
- ☐ emphysema
- ☐ pneumonia
- ☐ shortness of breath with exertion
- ☐ shortness of breath when sitting
- ☐ shortness of breath when lying down
- ☐ pain with breathing

Gastrointestinal:
- ☐ indigestion
- ☐ diarrhea
- ☐ constipation
- ☐ food intolerance
- ☐ abdominal pain

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- ☐ heartburn
- ☐ ulcers
- ☐ hemorrhoids
- ☐ gas/bloating
- ☐ nausea
- ☐ vomiting
- ☐ liver disease
- ☐ hernias
- ☐ fatty meals bothering
- ☐ rectal bleeding/ burning/itching

Urinary Tract:
- ☐ incontinence
- ☐ kidney stones
- ☐ blood in urine
- ☐ urgency
- ☐ frequent urination
- ☐ frequent infections
- ☐ pain with urination
- ☐ waking to urinate

Musculoskeletal:
- ☐ muscle weakness
- ☐ leg cramps
- ☐ muscle aches
- ☐ tremors
- ☐ arthritis
- ☐ stiffness
- ☐ past injury
- ☐ head injury

Integumentary:
- ☐ positive skin exam
- ☐ color changes
- ☐ abnormal mole
- ☐ dry skin
- ☐ acne
- ☐ rash
- ☐ hives
- ☐ dandruff
- ☐ oily hair
- ☐ hair/nail changes
- ☐ eczema
- ☐ psoriasis
- ☐ itchy skin
- ☐ rosacea
- ☐ skin cancer
- ☐ warts
- ☐ dry hair
- ☐ hair loss

Neurological:
- ☐ paralysis
- ☐ sciatica
- ☐ seizures
- ☐ weakness
- ☐ headaches
- ☐ migraines
- ☐ numbness/tingling
- ☐ tremors
- ☐ carpal tunnel
- ☐ fainting/blackouts
- ☐ dizziness
- ☐ lightheadedness

Mental/Emotional:
- ☐ anxiety
- ☐ fear/panic
- ☐ eating disorder
- ☐ anger/irritability
- ☐ feeling down/depressed
- ☐ suicidal thoughts

Endocrine:
- ☐ diabetes
- ☐ thyroid disease
- ☐ mood swings
- ☐ irritability
- ☐ hormone therapy
- ☐ increased urination
- ☐ increased thirst
- ☐ hot/cold intolerance
- ☐ needing to eat regularly
- ☐ snacking often
- ☐ change in glove/ shoe size

Hematologic/Lymphatic:
- ☐ anemia
- ☐ bruising/easy bleeding
- ☐ swollen lymph nodes
- ☐ circulation problems
- ☐ fragile/sensitive skin
- ☐ blood clots
- ☐ deep bone pain
- ☐ reaction to insect bites
- ☐ brittle nails

Allergic/Immunologic:
- ☐ sensitivity to chemicals
- ☐ dry or itchy eyes
- ☐ sinusitis
- ☐ organ transplant or donation
- ☐ sick often
- ☐ rash
- ☐ hives
- ☐ chemical exposure
- ☐ have pets

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SEXUAL/REPRODUCTIVE HEALTH

Contraception, Libido, and Sexually Transmitted Infections (STIs):
Are you currently sexually active?
☐ Yes ☐ No
Current number of sexual partners:________

Do you have sex with:
☐ Males ☐ Females
☐ Males and females ☐ Other

List safer sex methods, birth control methods and hormonal contraception previously and currently used:
____
____
Would you like information about safer-sex methods? ☐ Yes ☐ No

Do you want to start a family? ☐ Yes ☐ No
Would you like more information with respect to starting a family? ☐ Yes ☐ No

Previous Medical History:
Please list any hormones (estrogen, testosterone) previously or currently used:_______________________________
____
Would you like information about hormone therapy? ☐ Yes ☐ No

Have you been tested for HIV?
☐ Yes Date:____________ ☐ No
Are you HIV-positive?
☐ Yes ☐ No ☐ Unknown

Have you been diagnosed with/treated for hepatitis A, B, and/or C? ☐ Yes ☐ No
Have you been told you have chronic hepatitis B or C or are a hepatitis B or C carrier? ☐ Yes ☐ No
If yes, when?_________________________

Have you been diagnosed with/treated for:
☐ Bacterial vaginosis ☐ Chlamydia
☐ Gonorrhea ☐ Herpes
☐ HPV ☐ Syphilis

Menstrual Cycle:
Age at first menses:___________

First day of your last menstrual period:
____

Average length of your menstrual period (ie. 5-7 days):_________________

Average length of your menstrual cycle (ie. 21-28 days):_________________

Color of menstrual blood:_______________

Clots in menses? ☐ Yes ☐ No

Number of pads/tampons used on your heaviest day?________________
Number of pads/tampons used on your lightest day?________________

Indicate if you experience any of the following PMS/menses symptoms:
☐ diarrhea ☐ heavy bleeding
☐ bloating ☐ cramps
☐ food cravings ☐ fatigue
☐ mood changes ☐ backache
☐ headaches
☐ breast tenderness/swelling

Menopause:
Age at menopause:__________
Surgically induced menopause:
☐ Total hysterectomy
☐ Partial hysterectomy

Date of last DEXA scan (bone scan):______

Indicate if you experience any of the following menopause symptoms:

- ▢ hot flashes
- ▢ low libido
- ▢ night sweats
- ▢ palpitations
- ▢ mood changes
- ▢ joint pain
- ▢ incontinence
- ▢ sleep disturbance
- ▢ vaginal dryness
- ▢ brain fog

Breast Health:

Do you perform monthly self-breast exams?

▢ Yes ▢ No

Do you know how to perform a self-breast exam?

▢ Yes ▢ No

Indicate if you have any of the following symptoms:

- ▢ breast pain
- ▢ nipple discharge
- ▢ breast lump/mass

Date of last mammogram and results:

____

Gynecological History:

Date of last PAP and results:____________

____

Have you ever had an irregular PAP?

▢ Yes ▢ No If yes, list date and treatment:__________________________

Indicate if you have ever had any of the following pelvic diseases/conditions:

- ▢ ovarian cysts
- ▢ fibroids
- ▢ endometriosis
- ▢ ectopic pregnancy
- ▢ pelvic inflammatory disease
- ▢ other ovarian/uterine disease:_________

List any history of gynecological surgeries or procedures, including dates:__________

____

Indicate if you experience any of the following gynecological symptoms:

- ▢ vaginal itching
- ▢ vaginal odor
- ▢ pelvic pain
- ▢ abnormal discharge
- ▢ rashes or skin changes
- ▢ pain with intercourse
- ▢ bleeding after intercourse

Pregnancy History:

Indicate your number of:

pregnancies:______

miscarriages:______

abortions:______

vaginal births:______

C-sections:______

Vaginal birth after cesarean:______

Any complications with pregnancy?

▢ Yes ▢ No Explain:________________

Any difficulty conceiving?

▢ Yes ▢ No Explain:_______________

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Urological Section:
Indicate if you experience any of the following symptoms:

- ▢ BPH
- ▢ urinating at night
- ▢ prostatitis
- ▢ prostate cancer
- ▢ difficulty initiating urination
- ▢ incomplete urination
- ▢ dribbling of urine

Do you perform monthly testicular exams?
▢ Yes ▢ No

Do you know how to perform a testicular exam?
▢ Yes ▢ No

Date of last PSA test:_______________

Date of last prostate exam (digital rectal exam):__________________________

Indicate if you experience the following pelvic symptoms:

- ▢ testicular pain
- ▢ testicular swelling
- ▢ hernia
- ▢ penile discharge
- ▢ impotency/difficulty achieving or maintaining an erection
- ▢ low libido
- ▢ prostate disease
- ▢ rashes or skin changes

I attest that the above information is true to the best of my knowledge:

Patient Printed Name: ___________________________________

Patient Signature: _______________________________________ Date: __________________