New Patient Paperwork

Legal Name: _____ Preferred Name: _____

DOB: _____ Social Security Number: _____-_____-_____

Mailing Address: _____

Phone number: _____ Can we text you? Yes No

Email address: _____Can we email you? Yes No

Who referred you to us? _____

Sex assigned at birth (circle one): Female Male Intersex

Gender identity: Trans male Cis male Trans female Cis female Non-binary Other

Preferred pronouns (circle one): She/her He/him They/them Other _____

What is the purpose of your visit today? _____

_____

Please list any allergies to medications: _____

_____

Please list any medications you are currently taking (include drug, dose, & frequency):

_____

_____

_____

_____

Past Medical History

Please check if you have ever had any of the following:

____ Migraine Headaches

____ Blood clots/clotting disorders

____ Pulmonary embolism

____ Cancer

____ Stroke

____ High blood pressure

____ Ischemic heart disease

____ Peripartum cardiomyopathy

____ Sickle cell disease

____ Gallbladder problems

____ Liver tumors

____ Breast disease

____ Solid organ transplantation

____ Hepatitis

____ High cholesterol

____ Hypothyroid

____ Hyperthyroid

____ Epilepsy or seizures

____ Valvular heart disease

____ History of bariatric surgery

____ Ulcerative colitis or Crohn's disease

____ Lupus

____ Unexplained vaginal bleeding

____ Diabetes

____ Cervical cancer

____ Chronic kidney disease

____ Depression/anxiety

____ Mood disorders

____ Schizophrenia or psychosis

____ Gonorrhea/chlamydia

____ Syphilis

____ HIV

Please list any previous surgeries:

_____

_____

Social History

Do you use nicotine? Yes No What type? cigarettes/cigars vape smokeless

Frequency of use: _____

Do you want to quit? Yes I'm thinking about it No

Do you use alcohol? Yes No If yes, how often? _____

Do you use recreational drugs? Yes No If yes, what type? _____

Frequency of use: _____ IV drug use? Yes No

Do you exchange sex for drugs or money? Yes No

Sexual Health History

Have you been sexually active in the last 3 months? Yes No If no, skip to the next page

Sexual orientation: Gay Straight Bisexual Asexual Queer Other

Please circle each type of sex you have engaged in in the past 3 months:

Vaginal Anal insertive Anal receptive Oral

Do you use condoms (circle one): Always Usually Sometimes Rarely Never

How many sexual partners have you had in the last three months? _____

Of those partners listed above, how many of them were new? _____

What is the date of your last sexual encounter? _____

Do you have a concern for pregnancy? Yes No

Have you had a recent known exposure to any sexually transmitted infections (STIs)? Yes No

If yes, what were you exposed to? _____ When? _____ / _____ / _____

If you are having symptoms today, please describe: _____

_____

Contraceptive History

What is your current method of birth control?

____ The pill (combined hormonal)

____ The patch

____ The ring

____ The progestin-only pill

____ The depo shot

____ IUD (Skyla, Kyleena, Liletta, Mirena)

____ The copper IUD

____ The Nexplanon implant

____ The fertility awareness method

____ None/seeking pregnancy

____ Withdrawal

____ Condoms

____ Diaphragm/spermicide

____ Male relying on female method

____ Vasectomy

____ Post-menopausal status

____ Post-hysterectomy status

____ Infertility

____ Abstinence

Please check each type of birth control you have used previously:

____ I have never used birth control

____ I have only used condoms

____ The pill (combined hormonal)

____ The patch

____ The ring

____ The progestin-only pill

____ The depo shot

____ The hormonal IUD

____ The copper IUD

____ The Nexplanon implant

Of your previously used birth control methods, please describe why the method(s) were discontinued and how long they were used for:

_____

_____

Menstrual History

Today, which statement **best** describes your menstrual cycle?

____ I'm having regular periods. The date of my last period was: _____ / _____ / _____

____ My periods are irregular. The date of my last period was: _____ / _____ / _____

If your periods are irregular, please describe your cycles:

_____

____ I'm pregnant, or my last pregnancy ended within the last two months, or I'm breastfeeding

____ My periods have stopped on their own (I've had menopause).

____ I've had menopause, but now have periods because I am taking hormones.

____ I've had a surgery which stopped my periods

If your periods stopped because of surgery, what did you have removed?

____ One ovary only

____ Both ovaries

____ Uterus only

____ Uterus and one ovary

____ Uterus and both ovaries

____ I don't know

____ I've taken medication or have an IUD/implant which has stopped my periods.

Please list the medication: _____

If you are having periods, is the flow (circle one): Light Moderate Heavy

Do you have painful periods? Yes No

If yes, is the pain controlled with over-the-counter pain medication? Yes No

Do you find yourself unable to perform daily activities due to painful periods? Yes No

Do you grow more hair than is considered normal on your face, chest, or back? Yes No

Obstetric History

Total number of pregnancies: _____ Number of live births: _____

Number of miscarriages: _____ Number of terminations: _____

Pregnancy complications: _____

Health Maintenance Screening Test History

_____ Mammogram Date: _____ / _____ / _____ Abnormal? Yes No

_____ Colonoscopy Date: _____ / _____ / _____ Abnormal? Yes No

_____ Bone density Date: _____ / _____ / _____ Abnormal? Yes No

_____ Pap test Date: _____ / _____ / _____ Abnormal? Yes No

If history of abnormal pap, what were the results?

_____ NIL _____ ASC-US _____ LSIL _____ HSIL _____ HR HPV+

_____ AGC _____ ASC-H _____ Other _____ Unknown

Where was your last pap test performed? _____

Have you ever had a colposcopy? Yes No Date: _____ / _____ / _____

Abnormal? Yes No

Have you ever had a LEEP? Yes No Date: _____ / _____ / _____

Abnormal? Yes No