

#### **New Patient Paperwork**

Legal Name:	Preferred Name:						
DOB: Social	Social Security Number:						
Mailing Address:	Zip Code:						
Phone:	Can we text you about <i>normal</i> lab results? Yes						
Email address:			Can we e	mail you? Ye	es No		
Who referred you to us?							
Pharmacy Name:			Phone:				
Sex assigned at birth (circle one):	Female	Male	Intersex				
Preferred pronouns (circle one):	She/her	He/him	They/them	Other			
What is the purpose of your visit to	oday?						
Please list any drug allergies and th							
Please list any medications you are	e currently ta	king (include	drug, dose, & fr	requency):			

### **Pertinent Past Medical History**

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

Migraines w/ visual changes	Hyperthyroid
Blood clots/clotting disorders	Epilepsy or seizures
Pulmonary embolism	Valvular heart disease
Cancer; Type	History of bariatric surgery
Stroke/TIA	Ulcerative colitis or Crohn's disease
High blood pressure	Lupus
Ischemic heart disease	Unexplained vaginal bleeding
Peripartum cardiomyopathy	Diabetes
Sickle cell disease	Cervical cancer
Gallbladder problems	Chronic kidney disease
Liver tumors	Depression/anxiety
Breast disease	Mood disorders
Solid organ transplantation	Schizophrenia or psychosis
Hepatitis	Gonorrhea/chlamydia
High cholesterol	Syphilis
Hypothyroid	HIV

Please list any previous surgeries and the dates that they were performed:

## **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 t	hinking about i	t No			
Do you use alcohol?	Yes No	If yes, how o	ften?			
Do you use recreatior	nal drugs? Y	es No If yes	, what type?			
Frequency of use:			IV	drug use?	Yes No	
Do you exchange sex	for drugs or r	noney? Yes	No			
Sexual Health Hist	ory					
Have you been sexual	lly active in th	ne last 3 month	s? Yes N	No *If no,	skip to the r	iext page
Sexual orientation:	Gay Str	aight Bis	exual A	sexual	Queer	Other
Please circle each type	e of sex you ł	nave engaged ir	n in the past	3 months:		
Vaginal Anal in	sertive	Anal receptiv	ve Ora	al		
Do you use condoms	(circle one):	Always Us	ually S	ometimes	Rarely	Never
How many sexual part	tners have yo	u had in the las	t three mon	ths?	The last ye	ar?
What is the date of yo	our last sexua	l encounter?				
Do you have a concer	n for pregnar	ncy? Yes N	0			
Do you have a concer	n for STIs or o	other infections	? Yes N	0		
Have you had a recent	t known expc	sure to any sex	ually transm	itted infecti	ons (STIs)?	Yes No
What were you	u exposed to	(if known)?		Whe	n?/_	/
If you are having sym	ptoms today,	please describe	e:			

#### **Contraceptive History**

What is your current method of birth control?	None/seeking pregnancy
The pill (combined hormonal)	Withdrawal
The patch	Condoms
The ring	Diaphragm/spermicide
The progestin-only pill	Male relying on female method
The depo shot	Vasectomy
IUD (Skyla, Kyleena, Liletta, Mirena)	Post-menopausal status
The copper IUD	Post-hysterectomy status
The Nexplanon implant	Infertility
The fertility awareness method	Abstinence

*\*If you are here for birth control today,* please check each method you have used previously:

I have never used birth control	The progestin-only pill			
I have only used condoms	The depo shot			
The pill (combined hormonal)	The hormonal IUD			
The patch	The copper IUD			
The ring	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 brea	stfee	ding				
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 Uterus and one ovary						
Both ovaries Uterus and both ovaries						
Uterus only 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	He	avy				
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						
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 at	onormal pap, v	what we	re the res	ults?			
NIL	ASC-	US	LSI	L	HSIL		HR HPV+
AGC	ASC-	н _	Otł	ner	Unkno	own	
Where was your last pap test performed?							
Have you ever had a colposcopy? Yes No Date: / /							
Abnor	mal? Yes	No					
Have you ever	had a LEEP?	Yes	No [	Date: _	/	/	
Abnori	mal? Yes	No					