Basic Information

Today's Date: ___/___/_____

_____ ____/____/_____
Patient Name Date of Birth

Sex Assigned at Birth (Circle): M F

Gender (please choose what you identify with): ▫Man
▫Woman
▫Non-Binary
▫Transgender: M->F or F->M (please circle)

Pronouns Preferred:
▫He/Him/His
▫She/Her/Hers
▫They/Them/Theirs
▫Other:_____
▫Other:_____

When & where did you last receive healthcare?
_____

Reason?
_____
_

Concerns?
_____

List Medications, Food, or other Allergies:

Please list prescription medications/over the counter medications/supplements you are currently taking:

Medication:	dose/How often:	Reason:

Hospitalizations, Surgeries, or Major Injuries: Please list the types & when it occurred.

Type:	Date:	Reason:

Family History: Please identify below who has or have had any of the following:
M = Mother F = Father

▫ Cancer (type): M__ F__ ▫ Kidney Disease: M___ F___.
▫ Alzheimer's: M___ F___ ▫ Diabetes: M___ F___
▫ Seizures: M___ F___. ▫ Bleeding Disorder: M___ F___
▫ Heart Disease: M___ F___ ▫ Stroke: M___ F___.
▫ Thyroid Disorder: M___ F___ ▫ High Blood Pressure: M___ F___
▫ Birth Defects: M___ F___ ▫ Hypoglycemia: M___ F___
▫ Osteo-porosis/penia: M___ F___

Preventative Exams (please list the date of your last one if applicable):

Screening Type-	Date:	Screening Type-	Date:
PAP SMEAR:		**History of abnormal pap/hpv:**	
MAMMOGRAM:		**DENTAL EXAM:**	
BREAST EXAM:		**EYE EXAM:**	
COLONOSCOPY: (OR OTHER COLON SCREENING)		**ANNUAL EXAM:**	
DEXA SCAN:		**PROSTATE EXAM:**	

Contraceptive History:
Birth control methods (both current and past):_____
List any problems with these birth control methods:_____
GYN history:*If Applicable*
First day of last period:_____
No menses yet ▫ Going through menopause now ▫
Age when periods started:
Never been pregnant ▫
Age at first pregnancy:_____
List any problems with menses, pregnancy, birth, or abortion:
_____
_____
_____

Sexual History:
No Intercourse Yet ▫ (If yes, skip to next section)
How many people have you had sex with in the last year? _____
Have you had sex with someone new in the last 90 days? ▫ **Y** ▫ **N**
Is your sexual contact (check all that apply): Vaginal ▫ Oral ▫ Anal ▫
Other:_____
Immunization History:
_____
_____
_____

_____

Social History:

Do you sleep well? ▫ **Y** ▫ **N** Do you wake rested?_____ Average hours of sleep per night:__

Tobacco use? ▫ **Y** ▫ **N**_____If yes, # of cigarettes/day:_____

Alcohol use? ▫ **Y** ▫ **N** # of Drinks/Week:_____

Treatment for alcoholism? ▫ **Y** ▫ **N** When:_____

Cannabis Use? ▫ **Y** ▫ **N** If yes, how often?_____

Other Recreational Drugs? ▫ **Y** ▫ **N**___If yes what?_____ How often? _____

Treated for drug abuse? ▫ **Y** ▫ **N** When:_____

Do you use any vape products?___ ▫ **Y** ▫ **N** If yes, what?_____ How often?_____

Do you watch TV?__ ▫ **Y** ▫ **N** _____If yes, how many hours/day?_____

Do you read?_____ ▫ **Y** ▫ **N** _____If yes, how many hours/day?_____

Do you feel safe at home?
_____

Exercise_____.
_____.

Do you exercise? ▫ Y ▫ N If so, how often?
What type(s)?

Diet & Nutrition_____

Do you have at least three meals a day ▫ Y ▫ N
Do you have any dietary restrictions? ▫ Y ▫ N
If so, what are they?
_____

Do you have a history of eating disorders? If so, which type and for how long?
_____
_____
_____

Please CIRCLE the highest grade level completed: 1 2 3 4 5 6 7 8 9 10 11 12 College 1 2 3 4
Please CIRCLE: Single Married Divorced Widowed

Occupation:____