Phone:
Fax:

New Patient Intake -

Nerissa S. Guballa MD 408 East 76th St NY, NY 10021

Name **DOB**

Reason for Visit

Date **Referred by**

Do you have any of the following problems?

Generalized Symptoms	Yes / No
Anxiety:	☐ ☐
Depression:	☐ ☐
Diabetes:	☐ ☐
Fatigue:	☐ ☐
High Cholesterol:	☐ ☐
Nervousness:	☐ ☐
Seizures:	☐ ☐
Sleep Disorders:	☐ ☐
Stress:	☐ ☐
Substance Abuse:	☐ ☐
Thyroid - Overactive:	☐ ☐
Thyroid - Underactive:	☐ ☐

Urinary	Yes / No
Painful Urination:	☐ ☐
Urinary Incontinence:	☐ ☐

Head / Ear / Nose / Throat	Yes / No
Earaches or Drainage:	☐ ☐
Headache:	☐ ☐
Hearing Loss or Ringing:	☐ ☐
Sinus Problems:	☐ ☐
Vision Changes:	☐ ☐

Respiratory	Yes / No
COPD:	☐ ☐
Shortness of Breath:	☐ ☐
Wheezing:	☐ ☐

Cardiovascular	Yes / No
Chest Pain:	☐ ☐
Congestive Heart Failure:	☐ ☐
Heart Attack:	☐ ☐
Heart Murmur:	☐ ☐
Hypertension:	☐ ☐

Phone:
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Urinary Urgency: ☐☐

Musculoskeletal	**Yes / No**
Back Pain:	☐☐
Joint Pain:	☐☐
Muscle Cramps:	☐☐

Gastrointestinal	**Yes / No**
Abdominal Pain:	☐☐
Constipation:	☐☐
Diarrhea:	☐☐
Heartburn:	☐☐

Gynecological	**Yes / No**
Cervical Disease:	☐☐
Genital Sores:	☐☐
Heavy Bleeding:	☐☐
Vaginal Discharge:	☐☐
Vaginal Itching:	☐☐
Vaginal Odor:	☐☐

Contraception Method:

Do you have any of the following symptoms?

	Yes / No
Bloating:	☐☐
Breast Tenderness:	☐☐
Cramping:	☐☐
Moodiness:	☐☐

Menstrual History

Date of Your Last Menstrual Period:

Age You Had Your First Period:

Menstruation every days.

Length of Menstruation days.

Menstrual Bleeding

Light ☐
Moderate ☐
Heavy ☐

Obstetric History

Total Number of Pregnancies:
Abortions - Elective:
Full Term Births:
Miscarriages:

Premature Births:
Multiple Births:
Ectopic:
Total Number of Children:

Phone:
Fax:

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Prefer 30 Day Refill: ☐
Prefer 90 Day Refill: ☐

List Any Known Allergies:

Social History

Marital Status:

Smoker - Cigarettes per Day:

Alcohol - Drinks per Week:

History of Drug Use:

	Yes / No
Are You Employed?	☐ ☐

Occupation:

Sexual Activity		**Partners**	
Never:	☐	Spouse:	☐
Current:	☐	Significant Other:	☐
Past:	☐		

Name of emergency contact **Relationship**

Phone:
Fax:

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Menopause History

Age at Menopause:

	Yes / No		Yes / No
Taking Hormone Therapy:	❒ ❒	Night Sweats	❒ ❒
Hot Flashes:	❒ ❒	Painful Intercourse:	❒ ❒
Insomnia:	❒ ❒	Skipping Periods:	❒ ❒
Irregular Bleeding:	❒ ❒	Vaginal Dryness:	❒ ❒

List Any Additional Medical Problems:

List Any Past Surgeries and the Date Performed:

List Current Medications:

Pharmacy Name - Preferred:

Pharmacy Name - Mail Order:

Phone:
Fax:

New Patient Intake -

Emergency contact phone: