New Patient Intake

Demographics

Legal Name:

Preferred Name:

Date of Birth: ____/____/_________

What Sex Were You Assigned at Birth:
- Female
- Male
- Intersex
- Choose not to disclose

Preferred Pronouns:
- She
- He
- They
- Other: _______

Gender Identity:
- Woman
- Man
- Trans: MTF
- Trans: FTM
- Non-Binary/Genderqueer/Neither
- Other: ______________
- Choose not to disclose

Medical Concerns

Chief Concerns (list in order of importance):

1.

2.

3.

Medical History

Please list other physicians you currently see and for what reason. Please include primary care physician and any specialists (cardiologist, rheumatologist, etc.)

1.

Date of last physical exam: ___/___/______
Date of last blood work/labs: ___/___/______

Please list any prior diagnoses related to your chief concerns, and any other major diagnoses you've received:

1.____________________________ 4.____________________________

2.____________________________ 5.____________________________

3.____________________________ 6.____________________________

Please list all medications and supplements that you take, including frequency and dosages:

1.

2.

3.

Please list all surgeries, hospitalizations, accidents, and major injuries with corresponding (approximate) dates:

1.

Do you have any allergies?

Foods: ________________

Environmental: _________________

Medications: __________________

No Known Allergies

Family History

Have any blood-relatives had any of the following? If so, list which relative (ex. Mother or maternal/paternal grandfather, son, etc)

- Heart attack
- Heart disease
- Stroke
- Cancer
- Asthma
- Diabetes
- Mental illness
- High blood pressure
- High cholesterol
- Autoimmune disease
- Neurodegenerative disease
- Osteoporosis
- Allergies
- Celiac disease
- Other: ________________

Social History

Current Occupation: _________________

Do you enjoy your job: _________

Hobbies: _______________________________________

Have you traveled outside of the country in the last year or two? If so, where?

Do you use any of the following? If so, please indicate what and how often, or if used in past.

Alcohol: ______________________

Tobacco: ____________________

Cannabis: _____________________

Caffeine: ______________________

Recreational drugs: _____________

Have you ever been treated for an addiction? If so, please explain.

Relationship Status:

Single	Divorced
Married	Separated
In a relationship	Widowed
Domestic partnership	Other: ____________

Are you satisfied in your relationship? ____

Do you live alone?

Yes

No: __________________

Do you have a history of abuse? Check all that apply.

No

Physical

Psychological

Sexual

Emotional

You can stop here. ☺ Your physician will go over the rest with you during your first visit. However, you may find it beneficial to read through the rest in order to think about some of the answers ahead of time. This is a very comprehensive list, so only fill it out if you are compelled to do so.

Review of Systems

Do you currently have, or have you had in the past year, any of the following?

Constitutional:

- Fatigue
- Night sweats
- Weight changes
- Loss of appetite
- Fever/chills
- Chronic pain

Rate your overall energy on a scale from 1 to 10, with 10 being excellent energy: _______
When is your energy the best? ____________________
When is your energy the worst? _____________________

Sleep:

- Trouble falling asleep
- Frequent waking in the night
- Nightmares
- Sleep walking
- Teeth grinding
- Sleep paralysis
- Bed wetting
- Snoring
- Other: ____________

How many hours do you sleep per night, on average? _______
Do you wake feeling refreshed?

- Always
- Sometimes
- Rarely
- Never

Mental/Emotional:

- Depression
- Anxiety
- Hallucinations
- Paranoia
- Mood swings
- Fear/panic
- Anger/irritability
- Suicidal thoughts
- Eating disorders
- Obsessive/ compulsive behaviors

Have you ever been hospitalized for a psychiatric condition? ____________________________
Please list any prior psychiatric diagnoses: ____
Do you have, or have you had recently, a therapist? ___________________________________

What stressors do you have?

- Work
- Romantic relationship
- Home life
- Money
- Health
- Family
- Friendships
- Other: _____________

Do you have a good emotional support system? ______________________________________

Eyes:

Dryness	Floaters	Dark circles
Itching	Discharge	Cataracts
Burning	Blurry vision	Glaucoma
Foreign body sensation	Worsening vision	Other: _______
Watering	Pain	
	Styes	

Ears & Nose:

Ringing in ears	Frequent falls	Sinus pain
Ear wax	Nasal polyps	Nasal congestion
Ear infections	Runny nose	Other: ___________
Painful ears	Loss of smell	
Hearing loss	Nosebleeds	
Dizziness/vertigo	Sinus infections	

Mouth/Throat:

Sore throat	Cavities	Voice changes/ hoarseness
Post-nasal drip	Canker sores	Changes in tasting
Swollen tonsils	Cold Sores	Other: _____________
Gum disease	Problems swallowing	
Bad breath		

Cardiovascular:

Murmur	Shortness of breath	Heart disease
Palpitations	Clots/clotting disorders	High/Low blood pressure
Arrhythmias	Varicose veins	High cholesterol
Pacemaker	Arms/legs going to sleep	
Heart attack	Edema	
Stroke/TIAs		
Chest pain		

Pulmonary:

Shortness of breath	Chronic bronchitis	Cough
Difficulty breathing	Lung Cancer	Pneumonia
Asthma	Wheezing	
Emphysema	Tuberculosis	

Gastrointestinal:

Belching
Heartburn
Nausea
Vomiting
Pain in stomach
Gastritis
Ulcers
Abdominal pain
Gallstones
Cholecystectomy
Pancreatitis
Liver disease/hepatitis
Hernias
Cancer
Ulcerative Colitis/Crohns
IBS
Loose stools/diarrhea
Constipation
Blood in stools
Hemorrhoids
Black/tarry stools

Date of last colonoscopy: ___/___/______
Food Intolerances: ____
Number of bowel movements per day: ______
Do you follow a specific diet?

Kidney/Urinary:

Kidney infections
Kidney stones
Cancer
Painful urination
Frequent urination
Blood in urine
Urgency
Urinary incontinence
UTIs
Other: ___________

Musculoskeletal:

Weakness
Tremors
Spasms
Stiffness
Painful joints
Swollen joints
Cramps
Muscle pain
Other: ________

Neurological:

Tremors
Spasms
Pins & Needles
Difficulty walking
Frequent falls
Memory loss
Numbness
Changes in behavior
Seizures
Paralysis
Headaches/ Migraines
Fainting
Dizziness
Other: ________

Endocrine:

- Hypothyroid
- Hyperthyroid
- Goiter
- Diabetes
- Cold intolerance
- Heat intolerance
- Increased urination
- Increased thirst
- Low/high libido
- Hormone replacement
- Changes in hair/skin/nails

Skin:

- Cancer
- Moles
- Difficulty healing wounds
- Ulcers
- Eczema
- Psoriasis
- Acne
- Hives
- Rash
- Rosacea
- Warts
- Itchy skin
- Dry/Oily skin/hair
- Other: ___________

Immunological/Hematological:

- Anemia
- Clotting disorders
- Sensitivity to smells
- Sensitivity to chemicals
- Seasonal allergies
- Frequent illness
- Organ transplant/ donation
- Easy bruising
- Bleeding
- Swollen lymph nodes
- Bone pain
- Poor circulation

Exercise:

How often do you exercise? ____

What type of exercise? ____

For how long do you exercise? ____

What prevents you from exercising? ____

Male Reproductive:

- Frequent waking to urinate
- Painful urination
- Unsteady stream
- BPH
- Prostate cancer
- Discharge
- Prostatitis
- Dribbling urine
- Difficulty initiating flow
- Testicular pain
- Testicular swelling
- Hernia
- Impotency
- Low libido
- Rashes
- Difficulty achieving erection
- Difficulty maintaining erection
- Other: ___________

Are you currently sexually active? ___________
Do you have sex with men, women, or both? ______________
Number of sexual partners in the past year: ______________
Date of last PSA: ___/___/______
Do you perform self-testicular exams? ________
Do you have a history of STIs? ________
How do you protect yourself from STIs? ____________
Do you currently take, or have you previously taken, hormones? _________________________

Female Reproductive:

Do you experience any of these during or before menses?

Diarrhea	Headaches	Breast tenderness/ swelling
Bloating	Cramping	Clots
Mood swings	Fatigue	
Food cravings	Back pain	

How long is your menses? _____________
Number of pads/tampons used? _______________

Breast Health

Breast pain	Itching	Lumps/masses
Skin changes	Discharge	Other: _______

Do you perform self-breast exams? ________

Do you currently have a gynecologist? _______________
Date of last PAP smear: ___/___/______
Are you currently sexually active? ________
Do you have sex with men, women, or both? ___________
Number of sexual partners in the last year? __________
Do you have a history of STIs? ____________
How do you protect yourself from STIs/pregnancy? _______________
Do you currently take, or have you previously taken, hormones? _________________________

Menopause

Hot flashes	Night sweats	Low libido
Mood swings	Vaginal dryness	Brain fog

Date of last DEXA scan: ___/___/______

Additional information you'd like your doctor to know: