TODAY'S DATE:______________________________

Legal name *(Last, First, MI)*:____ **DOB:** ______________________

Preferred name *(if different)*: ____ **PID:** _______________________

Preferred pronouns: □ He/Him □ She/Her □ They/Them □ Ze □ Other _______________________

Gender identity: □ Male □ Transmale/Transman/FTM □ Female □ Transfemale/Transwoman/MTF
□ Gender queer/gender non-conforming □ Different identity (*please state)*: ______________

Sex assigned at birth: □ Male □ Female □ Other

Reason for visit today: ____

MEDICATIONS:

List all current medications (dose and frequency):
1. ____
2. ____
3. ____
4. ____
5. ____

List all current supplements:
1. ______________________________________
2. ______________________________________
3. ______________________________________
4. ______________________________________
5. ______________________________________

ALLERGIES:

List drug allergies and reactions:
1. ____
2. ____
3. ____

List any food, insect or latex allergies and reactions:
1. _______________________________________
2. _______________________________________
3. _______________________________________

SURGERIES:
1. ____
2. ____

HOSPITALIZATIONS:
1. ____
2. ____

IMMUNIZATIONS:

Tdap *(booster received within 10 yrs?)*: □ No □ Yes □ Not sure

HPV *(completed 3 shots?)*: □ No □ Yes □ Series started □ Not sure

SOCIAL HISTORY:

Do you drink alcohol? □ No □ Yes

How many times a week? ____________

How many drinks per sitting? __________

History of alcohol abuse? □ No □ Yes

Do you use drugs? □ No □ Yes

(type of drugs): ___________________________

Do you use tobacco or nicotine products? □ No □ Yes

(type): □ cigarettes □ cigars □ e-cigs (JUUL) □ smokeless tobacco

How many per day? _________

Frequency of use? □ daily □ weekly □ monthly □ rarely

For how long? ___________

Past history of smoking? □ No □ Yes Date quit:___________

EXERCISE:

Do you exercise? □ No □ Yes Activity? ___________________________________ How often? _________________

Duration *(minutes per session)*: □ <15 □ 15-30 □ 30-45 □ 45-60 □ >60

PID:________________________________

MEDICAL CONDITIONS: current and past

	No	Yes		No	Yes
ADHD			Liver disease, hepatitis or tumor		
Blood clots or other bleeding disorders			Lupus		
Cancer: type_________________________			Migraine headache: □ without aura □ with aura		
Diabetes: □ Type 1 □ Type 2			Seizures		
Eating disorder			Thyroid		
Heart disease or condition			Rheumatoid/Juvenile rheumatoid arthritis		
High blood pressure			UTI (frequent)		
High cholesterol			Stroke or stroke like problems		
Kidney disease			Other: ___________________________________		

FAMILY HISTORY: Do you have a parent, sibling or grandparent with a history of the following?

	No	Yes	Which relative?	Age at diagnosis
Heart attack, angina				
Stroke				
High blood pressure				
High cholesterol				
Diabetes				
Thyroid disease				
Breast cancer				
Other cancer: type(s): ___________________________________				
Blood clot (DVT, PE) or other bleeding disorders				
Mental health disorders				
Other				

REVIEW OF SYSTEMS: Please indicate any **current** symptoms (within past three months)

GENERAL	□ Fatigue □ Chills □ Night sweats □ Fever □ Weight gain □ Weight loss
SKIN	□ Rash □ New or changing moles □ Excessive hair on skin □ Bumps or sores on skin
EYES	□ Redness □ Vision changes □ Itchy eyes □ Light sensitivity □ Eye pain □ Eye discharge
EAR, NOSE,THROAT	□ Hearing loss □ Ringing in ears □ Trouble swallowing □ Nasal congestion/drainage
RESPIRATORY	□ Cough □ Wheezing □ Shortness of breath
CARDIOVASCULAR	□ Chest pain □ Leg swelling □ Irregular heartbeat
BREAST	□ Nipple discharge □ Breast pain □ Lumps
NEUROLOGICAL	□ Dizziness □ Fainting □ Headache □ Numbness □ Tingling □ Tremors □ Weakness □ Seizures □ Trouble walking or falls □ Memory loss
MENTAL HEALTH	□ Anxiety □ Depressed mood/Low mood □ Self harming/cutting □ Suicidal thoughts □ Thoughts of harming others □ Hallucinations □ Paranoia □ Sleep problems
ENDOCRINE	□ Cold intolerance □ Heat intolerance □ Excessive thirst □ Hot flashes
MUSCULOSKELETAL	□ Muscle aches □ Joint stiffness □ Joint pain □ Joint swelling □ Neck pain □ Back pain
HEMATOLOGIC	□ Easy bleeding □ Easy bruising □ Swollen lymph nodes □ Blood clots
GASTROINTESTINAL	□ Abdominal pain □ Heartburn □ Constipation □ Diarrhea □ Nausea □ Vomiting □ Blood in stool □ Loss of appetite
GENITOURINARY	□ Pain or burning on urination □ Frequent urination □ Leakage of urine □ Weak urinary stream □ Awakening at night to urinate more than once □ Blood in urine □ Decreased sexual desire □ Pain with sex □ Problems with orgasm □ Genital sore/rash/itching □ Problems with erection □ Penile discharge □ Testicular discomfort □ Vaginal dryness □ Unusual vaginal discharge

PID:________________________________

SEXUAL/RELATIONSHIP HISTORY:

Do you think of yourself as: □ Straight or heterosexual □ Lesbian, gay or homosexual □ Bisexual □ Queer □ Don't know □ Decline to answer

Do you have sex with: □ Men □ Women □ Both □ Not applicable

What do you use for birth control *(if applicable):* □ Condoms/Dams/Diaphragm □ Birth control pills □ Nuvaring □ IUD *(type)*:____________ □ Nexplanon/Implanon □ Depo-Provera □ Tubal ligation □ Vasectomy □ Withdrawal □ Nothing

History of sexually transmitted infections (STI)? □ No □ Yes □ Never tested □ Not applicable

When was your last STI screening? ________________ □ Never tested □ Don't know □ Not applicable

Do you wish to be screened for STI today? □ No □ Yes □ Not applicable

Have you had new sexual contact(s) since last STI screening? □ No □ Yes □ Not applicable

Have you been physically hurt by your partner or ex-partner? □ No □ Yes

Have you been emotionally abused by your partner or ex-partner? □ No □ Yes

Have you had unwanted sexual activity as a child or as an adult? □ No □ Yes

GYNECOLOGIC HISTORY *(if applicable):*

Age at first period: ______________

First day of your last menstrual period: _________________

Regular periods? □ No □ Yes

Do you have bleeding between your periods? □ No □ Yes

Period comes every how many days? ______________

Period usually lasts how many days? ________________

Menstrual cramps: □ None □ Mild □ Moderate □ Severe

Menstrual flow: □ Light □ Moderate □ Heavy

PAP HISTORY *(if applicable)*:

Date of last PAP ___________________ □ Normal □ Abnormal *(result)*: ______________________________

Have you ever had an abnormal PAP? □ No □ Yes *(date)*: ________________

Have you ever had colposcopy? □ No □ Yes *(date)*: __________________

Have you ever had LEEP? □ No □ Yes *(date)*:__________________

PREGNANCY HISTORY *(if applicable)***:**

Currently pregnant? □ No □ Yes

Currently breastfeeding? □ No □ Yes

Pregnancy outcomes: □ Birth #______ □ Abortion # ______ □ Miscarriage #______ □ Ectopic pregnancies # ______

Complications or comments: ____