BALCONES GYNECOLOGY

# New Patient Intake Form

Please complete this brief history to assist me in providing you with the best care possible.
This form will be added to your medical record.

Name: _____ Preferred Name _____ Preferred Pronoun(i.e. she/he; her/him) _____

Date of Birth: 0 Who referred you? _____

Reason for visit: _____

## Sexuality/Gender Identity

What is your sexual orientation?
- ☐ Straight/Heterosexual
- ☐ Lesbian/Gay
- ☐ Bisexual
- ☐ Other _____
- ☐ Decline to state

What sex were you assigned at birth?
- ☐ Female
- ☐ Male
- ☐ Decline to state

What is your gender identity?
- ☐ Female
- ☐ Transgender woman/Transwoman
- ☐ Male
- ☐ Transgender man/Transman
- ☐ Gender queer/Gender non -conforming
- ☐ Decline to state

## Recent Exam

| Type of exam | Date of last exam | Location of exam |
|---|---|---|
| Pap test | | |
| Mammogram | | |
| Colonoscopy | | |
| Pelvic/Transvaginal ultrasound | | |
| Bone density study | | |

## Gynecologic History

Date of last menstrual period: _____

Age (years) at 1st period _____; My period usually occurs every_____ days and lasts for _____days; Age at Menopause_____

Do you have a history of (If yes please provide date and describe):

- ☐ Ovarian cysts _____
- ☐ Fibroids _____
- ☐ Abnormal Pap test _____
- ☐ Sexually Transmitted Infection _____

Have you ever used oral contraceptives (if so for how many years)? _____

Have you ever used hormone replacement therapy (if so for how many years)? _____

Are you sexually active? ☐ No ☐ Yes Any problems? _____

Total number of pregnancies _____

# of Vaginal deliveries ___; Cesarean sections ___; Miscarriages ___; Abortions ___; Ectopic pregnancies ___;

Pregnancy Complications_____

## Current Medications (include vitamins, herbs and other supplements)

Please review your attached medication list. Please add/remove medications based on what you currently take.

| Name of Medication | Dosage | How Often |
|---|---|---|
| | | |
| | | |
| | | |

## Allergies

**Are you allergic to any medications?** ☐ No ☐ Yes (Please specify the medication and reaction):

## Medical History (either now or in the past/detail below with year of diagnosis and treatment given)

- ☐ Asthma
- ☐ Cancer
- ☐ Cardiac disease
- ☐ Diabetes
- ☐ Hypertension / high blood pressure
- ☐ Hyperlipidemia / cholesterol
- ☐ Irritable bowel syndrome
- ☐ Inflammatory bowel disease
- ☐ Lupus
- ☐ Osteoporosis / osteopenia
- ☐ Stroke
- ☐ Thrombotic disorder (blood clots)
- ☐ Thyroid disease (low / high)
- ☐ Reflux (GERD)

Psychiatric diagnosis
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar disorder
- ☐ Other: _____

_____

_____

Name: _____ Date of visit: _____

## Surgical History

| Name of Procedure | Date of Procedure | Reason for Procedure |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## Family History

Do you have a family member with any of the following cancers (if yes please list which family member and age of diagnosis)

- ☐ Breast cancer _____
- ☐ Ovarian cancer _____
- ☐ Uterine/endometrial cancer _____
- ☐ Prostate cancer _____
- ☐ Pancreatic cancer _____
- ☐ Colon cancer _____
- ☐ Melanoma _____
- ☐ Other cancer (specify) _____

Mother: ☐ Living ☐ Deceased (cause) _____

Father: ☐ Living ☐ Deceased (cause) _____

Siblings: Number living: _____ Number deceased: _____ Cause: _____

## Social History

Do you exercise? If so what do you do _____

Occupation_____ Marital Status_____

Do you smoke? _____ How many packs a day? _____ If you quit, when was this? _____

Do you drink alcohol? _____ How many drinks per week? _____ Any other drugs? _____ Which other drugs?_ _____

| **Review of Systems:** Are you experiencing any of the following symptoms? | | | | | |
|---|---|---|---|---|---|
| Constitutional | ☐ No | ☐ Weight loss | ☐ Weight gain | ☐ Fever | ☐ Fatigue |
| Eye Problems | ☐ No | ☐ Vision Changes | ☐ Glasses | ☐ Contacts | ☐ Other |
| Ear, Nose, Throat | ☐ No | ☐ Ulcers | ☐ Sinusitis | ☐ Headache | ☐ Hearing Problems |
| Cardiovascular | ☐ No | ☐ Chest pain | ☐ Leg Swelling | ☐ Palpitations | ☐ Other |
| Respiratory | ☐ No | ☐ Wheezing | ☐ Cough | ☐ Shortness of Breath | ☐ Other |
| Gastrointestinal | ☐ No | ☐ Diarrhea | ☐ Constipation | ☐ Nausea | ☐ Vomiting |
| Urinary | ☐ No | ☐ Painful Urination | ☐ Urgency | ☐ Frequency | ☐ Bloody Urine |
| Skin/Breast | ☐ No | ☐ Breast Pain | ☐ Nipple discharge | ☐ Breast Mass | ☐ Skin Rash |
| Neurological | ☐ No | ☐ Fainting | ☐ Seizures | ☐ Numbness | ☐ Trouble Walking |
| Psychiatric | ☐ No | ☐ Depression | ☐ Anxiety | ☐ Other | |
| Blood/Lymph | ☐ No | ☐ Easy Bruising | ☐ Abnormal Bleeding | ☐ Swollen Glands | ☐ Other |
| Musculoskeletal | ☐ No | ☐ Weakness | ☐ Pain | ☐ Other | |

## Physicians

Medical / primary care physician: _____ Phone #_____

**Obstetrician / Gynecologist:** _____ Phone # _____

**Cardiologist:** _____ Phone # _____

**Other physician:** _____ Phone # _____

**Other physician:** _____ Phone # _____