**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth/Age: \_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_**

What is the primary reason for your visit? \_\_ I have an illness/injury or other concern:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Consultation only\_\_ Are you an established patient at this office? \_\_Y \_\_N If not,

\_\_ Are you establishing care at this office? \_\_Y \_\_N

Please identify your primary provider (if you have one): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Location

Please explain your health concern, including how long this has been a concern and the level of significance you place on the matter:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been diagnosed with any chronic disease? \_\_Y \_\_N

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications**:

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_\_\_

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_\_\_

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_\_\_

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_\_\_

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_\_\_

**Current Supplements**:

\_\_ Multiple Vitamin (Brand: \_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Supplement:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_\_\_

Supplement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_\_\_

Supplement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_\_\_

Supplement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency: \_\_\_\_\_\_\_\_\_\_

**Do you have drug or food allergies? \_\_Y \_\_N**

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Smoking History:**

Do you currently smoke? NO \_\_ Yes: Cigarettes \_\_ Cigars \_\_ Pipe \_\_ Vape: \_\_\_\_\_\_\_\_\_\_\_\_

Packs per day Cigars/day Times/day

Do you want to quit smoking? \_\_Y \_\_N

**Bowel Movements:**

How many bowel movements do you typically have each day: 0—1—2—more

How would you describe your recent stools?

\_\_Solid, well formed; no strain to pass \_\_Hard; difficult to pass \_\_Loose/Diarrhea

\_\_Foul-smelling \_\_Floating \_\_Greenish \_\_White/Clay-colored \_\_Use laxatives

Have you recently noticed blood on the tissue or in the water after your stool: **Y N**

Have you noticed or suspected hemorrhoids: **Y N**

**Energy Level:**

What has your energy level been for the past several days? 1--------5--------10 (10 is best)

How much sleep is normal for you? 4—6—8 –10 hours per night

**Stress**: How would you rate your current stress level: 1--------5--------10 (10 is worst)

What is the primary cause of your stress? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Occupation:** What type of work do you do?

\_\_Full-time Student \_\_Part-time student \_\_Retired; How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Teacher/Instructor \_\_Hospitality \_\_Entertainment/Sports

\_\_Service Industry \_\_Landscape/Pest Control \_\_Auto Repair

\_\_Outside Sales \_\_Retail Sales \_\_Research

\_\_Office Type of business: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Healthcare Type of clinic or facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**:

\_\_Past or current alcohol use Date of last use: \_\_\_\_\_\_\_\_\_\_\_\_\_ Alcohol volume/day: \_\_\_\_\_\_\_\_\_\_ N/A

|  |
| --- |
| \_\_Alcohol Dependency Are you a recovering alcoholic? **Y N** (Some medications are alcohol-based) |

\_\_Current recreational drug use Drugs used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Prescription Drug Dependency Drug(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you exercise on a regular basis? Y N** If yes, please describe the type and frequency of your exercise**:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hospitalizations:** Age/Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age/Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age/Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgeries:** Age/Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age/Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you recently had any laboratory studies or imaging (x-rays, CT, MRI, UltraSound) Y N**

Recent Labs: CMP CBC/Diff TSH Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recent Imaging: X-rays CT Scan MRI Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Men Only**

|  |  |
| --- | --- |
| * Do you experience pain with urination? | Y N |
| * + Have you recently noticed a discharge from your penis? | Y N |
| * + Have you recently noticed a wart, growth, or sore in your genital region? | Y N |
| * + If yes, have you ever been evaluated for or diagnosed with a sexually transmitted infection? | Y N |
| * Do you have any difficulty beginning or maintaining a stream of urine? | Y N |
| * + Do you frequently need to get up during sleep to urinate? | Y N |
| * Have you recently noticed blood in your urine? | Y N |
| * Are you satisfied with the currently flow of urine? | Y N |
| * Have you ever been evaluated for, or diagnosed with: \_\_\_BPH \_\_\_Prostate Cancer | Y N |
| * Do you have difficulties achieving or maintaining an erection? | Y N |
| * Do you have difficulties achieving climax? | Y N |
| * Do you think or say things such as “I’ve lost my mojo” or “I don’t have the drive I used to have?” | Y N |
| * Do you find that you are constantly fatigued? | Y N |
| * Do you have low sex drive/libido? | Y N |
| * Are you sometimes depressed? | Y N |
| * Do you have anxiety, or are you easily agitated? | Y N |
| * Have you been diagnosed with, or wondered about, low testosterone? | Y N |
| * Have you ever noticed blood in your stool? | Y N |
| * Have you ever had a colonoscopy?   If yes, date of most recent exam: | Y N |
|  |  |

**Patient Acknowledgment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Signature) (Date)

**Women Only**

* Your age when you began to have a monthly cycle (menarche): \_\_\_\_\_\_\_\_\_\_\_\_ years

**Children**: Number: PGYs: Date of your last PAP exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Have you noticed warts, sores or red areas in your genital area? **Y N**
* Have you had a hysterectomy? **Y N**
  + If yes:
    - Your age at the time of the hysterectomy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
    - Was your uterus removed? **Y N**
    - Were your ovaries removed? **Y N**
    - Are you currently using any hormones? \_\_Estrogen \_\_Progesterone \_\_Other
* Have you ever been diagnosed with cancer of the: \_\_Vulva \_\_Cervix \_\_Uterus \_\_Ovaries
* Current and Recent Sexual Habits: \_\_Active \_\_Not Active

\_\_Monogamous Is your partner Monogamous Y **N**

\_\_Multiple Partners \_\_Heterosexual \_\_ Homosexual \_\_Bisexual

**Breast Health**

* Have you ever been diagnosed with breast cancer **Y N**
  + If yes, did you undergo any of the following treatments:

\_\_Radical mastectomy \_\_Lumpectomy \_\_Removal of Lymph Nodes

\_\_Chemotherapy \_\_Radiation therapy \_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last mammogram: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last clinical breast exam: \_\_\_\_\_\_\_\_\_\_

Do you perform monthly breast self-exams? **Y N**

Have you noticed any lumps, bumps, dimpling? **Y N**

Do you experience breast pain during menstrual periods? **Y N**

Have you noticed unusual nipple discharges? **Y N**

**Non-menopausal:** Last menstrual period (start of bleeding): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How heavy is your period? Days \_\_\_\_ Pads\_\_\_\_ Tampons

Do you observe blood clots? **Y N**

Do you experience PMS? **Y N**

* Are you trying to become pregnant? **Y N**
* Are you currently using any form of birth control? **Y N**

**In Menopause:** When was your last period: \_\_\_\_ months ago

Are you currently experiencing symptoms of menopause: **Y N**

**Post-menopausal:** At what age did you enter menopause: \_\_\_\_\_ years of age

Have you experienced any of the following:

\_\_vaginal dryness or itching \_\_pain with intercourse

Are you currently using any hormones? \_\_Estrogen \_\_Progesterone \_\_Other

**Patient Acknowledgment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Signature) (Date)