# 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
- ☐ Married
- ☐ In a relationship
- ☐ Domestic partnership
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ 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

## 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
- ☐ Itching
- ☐ Burning
- ☐ Foreign body sensation
- ☐ Watering
- ☐ Floaters
- ☐ Discharge
- ☐ Blurry vision
- ☐ Worsening vision
- ☐ Pain
- ☐ Styes
- ☐ Dark circles
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Other: _____

**Ears & Nose:**

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

**Mouth/Throat:**

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

**Cardiovascular:**

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

**Pulmonary:**

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

**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
- ☐ Bloating
- ☐ Mood swings
- ☐ Food cravings
- ☐ Headaches
- ☐ Cramping
- ☐ Fatigue
- ☐ Back pain
- ☐ Breast tenderness/ swelling
- ☐ Clots

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

Breast Health

- ☐ Breast pain
- ☐ Skin changes
- ☐ Itching
- ☐ Discharge
- ☐ Lumps/masses
- ☐ 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
- ☐ Mood swings
- ☐ Night sweats
- ☐ Vaginal dryness
- ☐ Low libido
- ☐ Brain fog

Date of last DEXA scan: ___/___/_____

**Additional information you'd like your doctor to know:**