Appendix B

Sample New Patient Intake Form

Date: _____

Patient Intake Form

We'd like to welcome you as a new patient. Please take the time to fill out this form as accurately as possible so we can most appropriately address your health needs.

The confidentiality of your health information is protected in accordance with federal protections for the privacy of health information under the Health Insurance Portability and Accountability Act (HIPAA).

You will notice that we ask questions about race and ethnic background. We do this so we can review the treatment that all patients receive and make sure everyone gets the highest quality of care.

While this clinic recognizes a number of sexes/genders, many insurance companies and legal entities do not. Please understand that the legal name and sex listed on your insurance must be used on documents pertaining to insurance and billing. If your preferred name and pronouns are different from these, please let us know.

Please print all responses.

Name: _____

Address: _____

_____

Home Tel (___) ___ - ____
OK to leave a message? Y N

Work Tel (___) ___ - ____
OK to leave a message? Y N

Cell Tel (___) ___ - ____
OK to leave a message? Y N

Date of Birth: _____

Sex/Gender: M F Intersex Transgendered

Race (eg, African-American, Latino, Asian, etc)
_____

Ethnicity (eg, Mexican, Hawaiian, Irish, etc)
_____

Education Level: _____

Occupation: (Do you work outside the home? Please be specific in describing your work)
_____

1

Email Address: _____

OK to contact by email: Y N

Insurance Type: _____

ID#: _____

Subscriber: _____

Secondary Insurance: _____

ID#: _____

Subscriber: _____

Language Spoken Most Often:
At Home: _____
At Work: _____

Do You Need an Interpreter?
Y N

Number of Hours Worked per Week: _____

Religious/Spiritual Beliefs: _____

Relationship/Marital Status: (eg, single, married, partnered, living together, divorced)
_____

Name of Your Partner or Spouse: (if applicable)
_____

Do You Live with Anyone? Y N
_____

Number of Children: _____ Ages _____

Do You Feel Safe at Home?: Y N Sometimes

Have you felt threatened, controlled by, or afraid of a partner, family member, or caregiver?
Y N

Medical History

Please check all that apply

___ Emphysema
___ Tuberculosis
___ Pneumonia
___ Bronchitis
___ Asthma
___ Allergies
___ Heart Disease
___ Stroke
___ High Blood Pressure
___ Elevated Cholesterol
___ Diabetes
___ Venous Thrombosis
___ Hepatitis A
___ Hepatitis B
___ Hepatitis C
___ Cirrhosis
___ Anemia
___ Thyroid Trouble
___ Gallbladder Disease
___ Ulcers
___ Frequent Urinary Tract Infections
___ Sexually Transmitted Infections
___ Prostate Trouble
___ Cancer
___ Arthritis
___ Osteoporosis
___ Fractures
___ Migraines
___ Depression
___ Anxiety or Panic Disorder
___ Posttraumatic Stress Disorder
___ Alcohol or Substance Use Problem
Other: _____

Systems Review

Please check any of the following symptoms that you have recently experienced or are a concern to you.

General:

___recent weight loss ___recent weight gain ___fatigue

___fever ___changes in appetite ___night sweats

Skin:

___rashes ___lumps ___itching

___dryness ___color change ___hair or nail change

Head:

___headaches ___head injuries ___dizziness

Eyes: Date of last exam: ___/___/___

___glasses ___contacts

___pain ___double vision ___redness

___glaucoma ___cataracts

Nose:

___frequent colds ___nasal stuffiness ___hay fever

___nosebleeds ___sinus trouble ___dust/animal allergies

Ears:

___hearing loss

Mouth & Throat: Date of last dental exam: ___/___/___

___bleeding gums ___frequent sore throats ___hoarseness

Neck:

___goiter ___lumps/swollen glands ___pain

Breasts: Date of last mammogram: ___/___/___

___lumps ___pain ___nipple discharge

Respiratory:

___cough ___wheezing ___shortness of breath

___coughing up blood

Cardiac:

___heart murmur ___chest pain ___palpitations

___swelling of feet ___shortness of breath

Gastrointestinal:

___trouble swallowing ___heartburn or gas ___nausea

___vomiting ___rectal bleeding ___constipation

___diarrhea ___abdominal pain ___hemorrhoids

___jaundice (skin or whites of eyes turning yellow)

Urinary:

___frequent urination ___painful urination ___blood in urine

___stones ___difficulty urinating or difficulty holding urination

___waking up to go to the bathroom several times at night

Musculoskeletal:

___joint stiffness ___arthritis ___gout

___backache ___muscle pains ___muscle cramps

Peripheral Vascular:

___leg cramps while walking ___varicose veins
___thrombophlebitis

Neurological:

___fainting ___blackouts ___seizures

___weakness ___numbness ___tremors

___tingling hands or feet ___change in memory

Psychiatric/Psychological:

___anxiety ___depression ___phobias
___family problems ___eating disorder

Have you ever been hit, slapped, kicked, or otherwise physically hurt by someone?

___Yes, in the past year ___Yes, prior to this past year ___No

Has anyone ever forced you into having any type of sexual activity?

___Yes ___No

Hematologic:

___anemia ___easy bruising or bleeding

___blood transfusions: Year(s) _____

Endocrine:

___heat or cold intolerance ___excessive sweating

___excessive hunger ___excessive urinating

Do you experience chronic pain? Yes No

If YES, how is your pain managed (ie, physical therapy, medication, etc)?

_____

On a scale of zero to ten, with ten being the worst and zero being no pain, how would you rate your current pain? ____

Operations and/or Hospitalizations: (*Please list surgeries and/or hospitalization reasons and dates*)

_____

_____

_____

Current Medications: (*Please include any non-prescription drugs as well, eg, vitamins, aspirin, etc.*)

Medication Name	Dose	Frequency of Use
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

If you need more room, please list additional medications on back of last page.

Allergies: (*Please list any allergies you may have to medications and food*)

_____

Family Medical History

Please check all that apply.
___ Stroke
___ Heart Disease
___ High Blood Pressure
___ Thyroid Disease
___ Kidney Disease
___ Diabetes
___ Arthritis
___ Osteoporosis
___ Migraine Headaches
___ Alcoholism
___ Asthma
___ Depression
___ Anxiety
___ Cancer/Type(s): _____

Vaccinations/Prevention

Date of Last Tetanus Vaccination: ___/___/ _____

Have you received any of the following vaccines:

Hepatitis A? Yes No Not Sure

Hepatitis B? Yes No Not Sure

Pneumo vax? Yes No Not Sure

Have you had a blood test for Rubella (German Measles)?
Yes No Not Sure

Date of Last Colonoscopy: ___/___/____ ___ Check here if not applicable

How often do you wear seatbelts? _____

Are there any firearms kept in your home? Yes No

Does someone have power of attorney or healthcare proxy giving them the power to make decisions about your care in life-threatening situations?

No Yes: (*name of person and their relationship to you*)

_____

Do you have an advanced health directive, such as do not resuscitate?
Yes No

Gender Identity

Please list any questions, concerns, or comments you have, if any, about your gender or gender identity (sense of your femaleness/maleness).

_____
_____
_____
_____
_____
_____

Sexual Orientation & Sexual History

How do you identify in terms of sexual orientation?

_____

Are you attracted to (*check all that apply*):

___Men ___Women ___Transgendered Men ___Transgendered Women

Have you had sex with (*check all that apply*):

___Men ___Women ___Transgendered Men ___Transgendered Women

When you have sex, do you have (*check all that apply*):

___Oral Sex ___Vaginal Sex ___Anal Sex

How often do you use condoms when having:

Oral Sex: _____

Vaginal Sex: _____

Anal Sex: _____

When is the last time you had sex without using a condom?

_____

Do you have a primary (main) sexual partner? Yes No

Do you have any casual sexual partners? Yes No

When was the last time you were tested for HIV?

_____

What were the results? _____

Please check any of the following infections that you have had:

___Syphilis ___Gonorrhea ___Pelvic Inflammatory Disease

___Herpes ___Trichomonas ___Genital Warts

___ Yeast Infections ___Chlamydia ___Crabs

___ Bacterial Vaginosis

For each of the above that you checked, please note: 1) when the infection was, 2) if you completed treatment, 3) if your partner(s) were informed, and 4) if you need help telling your partners.

1) _____ 2) _____ 3) _____ 4) _____

1) _____ 2) _____ 3) _____ 4) _____

1) _____ 2) _____ 3) _____ 4) _____

1) _____ 2) _____ 3) _____ 4) _____

Do you know or believe that any of your partners have had HIV or another sexually transmitted infection?

Yes No I'm not sure

Have your current partners been tested for HIV and other sexually transmitted infections?

Yes No I'm not sure

What were the results? _____

Are you satisfied with your sexual life? Yes No I'm not sure

Please describe any sexual concerns you may have:

_____
_____
_____
_____
_____
_____

Gynecologic History

If not applicable due to sex and/or gender please check here ___ and skip to Hormones section

Age of First Period: ___

Date of Last Pap: ___/___/___ Results: ___Normal ___Abnormal

Have you *ever* had:

An abnormal Pap? Yes No Ovarian Cysts? Yes No

Fibroids? Yes No DES Exposure? Yes No

Have you had a hysterectomy? Yes No

If YES: Why was it performed?

_____

Were your ovaries removed? Yes, both Yes, one No

If menopausal/postmenopausal, please check here ___ and skip to below the dotted line

Date of Last Period: ___/___/___

Frequency of Periods: (*eg, every 28 days*) _____
Average Length of Period: ___days

Bleeding: ___Light ___Moderate ___Heavy

Other Bleeding: ___No ___Yes, between periods ___Yes, after penetrative sexual activity

Do you experience any of the following symptoms with your period? *Check all that apply.*

___Headaches ___Weight Gain ___Swelling ___Cramps ___Anxiety

___Depression Other: _____

Are you currently using birth control? Yes No

If YES: Which type are you using:

___Pills ___IUD ___Condoms ___Foam ___Foam & Condoms

___Patch ___Diaphragm ___Ring ___Depo ___Tubal Ligation

___Vasectomy Other: _____

Have you *ever* taken birth control pills?

Yes, for _____(how long?) No

Are you currently pregnant or planning to become pregnant?

Yes No

If you have not begun menopause, please check here ___ and continue to the next section

Age at menopause: ___

Have you *ever* taken estrogen replacement? Yes No

If YES: What was the name of the estrogen replacement?

_____

Age when estrogen replacement was started: _____

How long was estrogen replacement used? _____

What was your estrogen dose? _____

Have you *ever* taken progesterone? Yes No

If YES: How many days per month? ____

How long was progesterone replacement used? _____

What was your progesterone dose? _____

Please check any of the following symptoms of menopause you are having:

___ Hot Flashes ___Fatigue ___Anxiety

___Depression ___Insomnia ___Irregular Bleeding

___Vaginal Burning/Itching ___Vaginal Dryness

___Pain during Vaginal Penetration Other: _____

Obstetric History

How many times have you been pregnant? _____

How many miscarriages have you had? _____

How many pregnancy terminations have you had? _____

How many vaginal deliveries have you had? _____

How many caesarean sections have you had? _____

Have you had any ectopic pregnancies? Yes No

Have you had gestational diabetes? Yes No

Do you have a history of infertility? Yes No

Hormones for Gender/Sex Transitioning

If not applicable, please check here ___ and skip to the next section.

Are you currently taking hormones for gender or sex transitioning purposes? Yes No

If YES: How long have you been taking them? _____

What hormones are you taking?

_____

Have you ever used transitioning hormones in the past? Yes No

If YES to past or current hormone use, what types of complications, if any, have you experienced?

_____
_____
_____
_____

What types, if any, of sex reassignment surgery have you had?

_____
_____
_____

What types, if any, of other feminizing or masculinizing procedures have you had?

_____
_____
_____

What types of complications, if any, have you experienced following such surgeries and/or procedures?

_____
_____
_____
_____

What concerns or questions, if any, do you have regarding gender/sex transitioning?

_____
_____
_____
_____

Lifestyle & Health Habits

Do you follow a special diet? Yes No

If YES, please check appropriately:

___Vegetarian ___Vegan ___Low Fat

___Low Carb ___High Fiber ___Calorie Restriction

Other: _____

Have you ever binged, purged, or restricted your food intake?

No Yes, I have _____
(please describe)

What concerns, if any, do you have about your eating practices?

_____
_____
_____

How often do you exercise at a moderate or vigorous level for 30 minutes or more? _____

What type of exercise(s) and/or sports do you engage in?

_____
_____
_____
_____

On a typical day, how many cups of caffeine containing beverages (coffee, tea, soda, energy drinks, etc) do you have? _____

On a typical day, how many portions of calcium enriched food do you eat? _____

Portion = one cup of milk = one slice of cheese = one cup yogurt = 1/2 cup of ice cream

On a daily basis, how much calcium do you consume through tablets or chews?

<500 mg 600-1200 mg Not Sure

Substance Use History

How many drinks containing alcohol do you have, on average, per week?

_____

Have you ever been concerned about your drinking? Yes No Not Sure

Has anyone, including a family member, friend, or healthcare worker been concerned about your drinking or suggest you cut down?

Yes No I'm not sure

How many cigarettes do you smoke per day? _____

How old were you when you first started smoking? ____

Have you ever tried to quit smoking? Yes No NA

Are you interested in quitting smoking? Yes No NA

If you are a former smoker, how long ago did you quit?

_____

Please check any of the substances listed below that you have used, even if it was only once:

___ Marijuana

When was the last time you used it? _____

How frequently do you/did you use it? _____

___Cocaine

When was the last time you used it? _____

How frequently do you/did you use it? _____

How do/did you use it (ie, smoke, inject, sniff)? _____

___Crystal Meth

When was the last time you used it? _____

How frequently do you/did you use it? _____

How do/did you use it (ie, smoke, inject, etc)? _____

___Heroin

When was the last time you used it? _____

How frequently do you/did you use it? _____

How do/did you use it (ie, smoke, inject, etc)? _____

___Other Opiates (oxycontin, vicodin, percodan, etc)

When was the last time you used it? _____

How frequently do you/did you use it? _____

How do/did you use it (ie, orally, smoke, inject, etc)? _____

___Ecstasy/Mushrooms/LSD

When was the last time you used it? _____

How frequently do you/did you use it? _____

Other Substance(s):

_____

When was the last time you used it? _____

How frequently do you/did you use it? _____

How do/did you use it (ie smoke, inject, etc)? _____

Have you *ever* injected any type of substance? Yes No

Did you ever share your needle, cooker, cotton, rinse water, or any other part of your set?

Yes No I'm not sure

What types of problems has drug use caused for you (ie, relationships with others, problems at work, depression, anxiety, physical health, etc)?

_____

_____

_____

_____

What concerns, if any, do you have about either your past or current drug use?

_____
_____
_____
_____

Thank you for answering this comprehensive health history form. Your answers are confidential and will help us provide more complete and knowledgeable care of you.