**New Patient Information Form**

Welcome to the office! Date: \_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_ Age: \_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Family doctor’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_ lbs / kg

In your own words, please tell us why you are coming to the office:

**Health Information: Please fill out what applies to you**

How old were you when your **periods first started**? \_\_\_\_\_\_\_\_\_\_

How were they as a teenager? Normal Heavy Painful Regular/Irregular Missed school

**First day of last period**: \_\_\_\_\_\_\_\_\_\_\_

Do you get **premenstrual symptoms** (PMS)? YES NO

Do you have **cramps/pain** with your periods? YES NO Sometimes

Do you require **medication** for your periods? YES NO Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please tell us about each of your **PREGNANCIES** (if any), including miscarriages:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date** | **Place** | **Vaginal, C-section, miscarriage, etc** | **Complications** | **Baby weight at birth** |
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When was your **last Pap test**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any **abnormal** Paps in the past? YES NO

Have you had **HPV vaccinations**? School Self-pay NO

How many did you receive? 1 2 3 other

Age of **menopause**: \_\_\_\_

Have you used **hormone replacement** before: YES NO If so, when? \_\_\_\_\_\_\_\_\_

What are you currently using for **birth control**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tubes tied / Vasectomy

Condoms Withdrawal Natural (timed intercourse) Birth Control Pills

Patch Vaginal ring Needle (Depo-Provera) Other: \_\_\_\_\_\_\_

Please circle if you have had any of the following **infections**:

 Chlamydia Gonorrhea Herpes Genital warts

 HIV Hepatitis B or C Chancre Syphilis

Do you have major problems with **acne** (pimples, zits)? YES NO Just a little
Do you have major problems with facial **hair** growth? YES NO Just a little

Do you have troubles with **hot flashes** or sweats? YES NO Just a little

Do you have troubles with vaginal **dryness**? YES NO Just a little

Are you currently sexually active? YES NO Just a little

Is/Are your partner(s): Male Female Both

Do you have troubles with intercourse (sex)? YES NO Just a little

Do you experience pain with intercourse (sex)? YES NO Occasionally

Please list all **SURGERIES/OPERATIONS** you have had:

|  |  |  |
| --- | --- | --- |
| **Procedure** | **Date** | **Why** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Please list all ongoing **MEDICAL PROBLEMS** you may have:

|  |  |  |
| --- | --- | --- |
| **Name** | **How long** | **Notes** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Please list all your **MEDICATIONS**:

|  |  |  |
| --- | --- | --- |
| **Name** | **Dose** | **Why you take it** |
|  |  |  |
|  |  |  |
|  |  |  |
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Please list all of your **ALLERGIES**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any medical problems that run in your **FAMILY**? YES NO

Do you smoke cigarettes? YES NO If so, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you vape? YES NO If so, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use marijuana/THC? YES NO If so, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_