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: ________________  Date of Birth: _____________________
Address: ______________  Sex/Gender: M F Intersex Transgendered
______________________  Race (eg, African-American, Latino, Asian, etc)
Home Tel (___) ___ - ____  Ethnicity (eg, Mexican, Hawaiian, Irish, etc)
OK to leave a message?  Y N
Work Tel (___) ___ - ____  Education Level: _______________
OK to leave a message?  Y N
Cell Tel (___) ___ - ____  Occupation: (Do you work outside the home?
OK to leave a message?  Y N  Please be specific in describing your work)
<table>
<thead>
<tr>
<th>Email Address:</th>
<th>Number of Hours Worked per Week: ______</th>
</tr>
</thead>
<tbody>
<tr>
<td>OK to contact by email:</td>
<td>Y N</td>
</tr>
<tr>
<td>Insurance Type:</td>
<td>Religious/Spiritual Beliefs: ____________</td>
</tr>
<tr>
<td>ID#:</td>
<td>Relationship/Marital Status: (eg, single, married, partnered, living together, divorced)</td>
</tr>
<tr>
<td>Subscriber:</td>
<td>Name of Your Partner or Spouse: (if applicable)</td>
</tr>
<tr>
<td>Secondary Insurance:</td>
<td>Do You Live with Anyone? Y N</td>
</tr>
<tr>
<td>ID#:</td>
<td></td>
</tr>
<tr>
<td>Subscriber:</td>
<td></td>
</tr>
<tr>
<td>Language Spoken Most Often:</td>
<td>Number of Children: ______ Ages ______</td>
</tr>
<tr>
<td>At Home:</td>
<td>Do You Feel Safe at Home?: Y N Sometimes</td>
</tr>
<tr>
<td>At Work:</td>
<td></td>
</tr>
<tr>
<td>Do You Need an Interpreter?</td>
<td>Y N</td>
</tr>
<tr>
<td></td>
<td>Have you felt threatened, controlled by, or afraid of a partner, family member, or caregiver? Y N</td>
</tr>
</tbody>
</table>
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
<table>
<thead>
<tr>
<th>Respiratory:</th>
</tr>
</thead>
<tbody>
<tr>
<td>_cough</td>
</tr>
<tr>
<td>_wheezing</td>
</tr>
<tr>
<td>_shortness of breath</td>
</tr>
<tr>
<td>_coughing up blood</td>
</tr>
<tr>
<td>Cardiac:</td>
</tr>
<tr>
<td>_heart murmur</td>
</tr>
<tr>
<td>_chest pain</td>
</tr>
<tr>
<td>_palpitations</td>
</tr>
<tr>
<td>_swelling of feet</td>
</tr>
<tr>
<td>_shortness of breath</td>
</tr>
<tr>
<td>Gastrointestinal:</td>
</tr>
<tr>
<td>_trouble swallowing</td>
</tr>
<tr>
<td>_heartburn or gas</td>
</tr>
<tr>
<td>_nausea</td>
</tr>
<tr>
<td>_vomiting</td>
</tr>
<tr>
<td>_rectal bleeding</td>
</tr>
<tr>
<td>_constipation</td>
</tr>
<tr>
<td>_diarrhea</td>
</tr>
<tr>
<td>_abdominal pain</td>
</tr>
<tr>
<td>_hemorrhoids</td>
</tr>
<tr>
<td>_jaundice (skin or whites of eyes turning yellow)</td>
</tr>
<tr>
<td>Urinary:</td>
</tr>
<tr>
<td>_frequent urination</td>
</tr>
<tr>
<td>_painful urination</td>
</tr>
<tr>
<td>_blood in urine</td>
</tr>
<tr>
<td>_stones</td>
</tr>
<tr>
<td>_difficulty urinating or difficulty holding urination</td>
</tr>
<tr>
<td>_waking up to go to the bathroom several times at night</td>
</tr>
<tr>
<td>Musculoskeletal:</td>
</tr>
<tr>
<td>_joint stiffness</td>
</tr>
<tr>
<td>_arthritis</td>
</tr>
<tr>
<td>_gout</td>
</tr>
<tr>
<td>_backache</td>
</tr>
<tr>
<td>_muscle pains</td>
</tr>
<tr>
<td>_muscle cramps</td>
</tr>
<tr>
<td>Peripheral Vascular:</td>
</tr>
<tr>
<td>_leg cramps while walking</td>
</tr>
<tr>
<td>_varicose veins</td>
</tr>
<tr>
<td>_thrombophlebitis</td>
</tr>
<tr>
<td>Neurological:</td>
</tr>
<tr>
<td>_fainting</td>
</tr>
<tr>
<td>_blackouts</td>
</tr>
<tr>
<td>_seizures</td>
</tr>
<tr>
<td>_weakness</td>
</tr>
<tr>
<td>_numbness</td>
</tr>
<tr>
<td>_tremors</td>
</tr>
<tr>
<td>_tingling hands or feet</td>
</tr>
<tr>
<td>_change in memory</td>
</tr>
<tr>
<td>Psychiatric/Psychological:</td>
</tr>
<tr>
<td>_anxiety</td>
</tr>
<tr>
<td>_depression</td>
</tr>
<tr>
<td>_phobias</td>
</tr>
<tr>
<td>_family problems</td>
</tr>
<tr>
<td>_eating disorder</td>
</tr>
</tbody>
</table>
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)?
________________________________________________________________
________________________________________________________________
________________________________________________________________

15
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.