
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)

Email Address: _____ Number of Hours Worked per Week: _____

OK to contact by email: Y N Religious/Spiritual Beliefs: _____

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

ID#: _____

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

Secondary Insurance: _____

ID#: _____ Do You Live with Anyone? Y N

Subscriber: _____

Language Spoken Most Often: _____ Number of Children: _____ Ages _____

At Home: _____

At Work: _____ Do You Feel Safe at Home?: Y N Sometimes

Do You Need an Interpreter? Have you felt threatened, controlled by, or afraid of a partner, family member, or caregiver?
Y N
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:

- | | | |
|--|--------------------------------------|--|
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Pelvic Inflammatory Disease |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Trichomonas | <input type="checkbox"/> Genital Warts |
| <input type="checkbox"/> Yeast Infections | <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Crabs |
| <input type="checkbox"/> 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.