New Patient Health Survey

Name: _____ DOB: _____ Date: _____

Transferring care from: _____

Any specialists you currently see: _____

_____

List any specific concerns: _____

_____

Past and Present Illness: Circle any of the following that you have had.

Heart Disease	Diabetes	Reflux
High Blood pressure	Osteoporosis	Colitis
Stroke	Thyroid problems	Ulcer/gastritis
High cholesterol	Depression	Liver problems
Heart murmur	Anxiety	Hepatitis
Asthma	Panic attacks	Diarrhea
COPD	Mood problems	Constipation
Blood clots	Anemia	Arthritis
Skin problems	Cancer	Migraine headaches
Kidney stones	Other (describe)	

Hospitalizations/Surgeries: Include reason and approximate date. _____

_____

Allergies: _____

Medications: include any frequently used over the counter medicines and supplements.

Immunizations: List year of last -

Tetanus _____ Shingles _____

Pneumonia _____ Covid _____

Reproductive Health -

Are you currently sexually active? Yes No Monogamous? Yes No

Method of birth control (if applicable): _____

Have you ever been diagnosed or treated for an STI? Yes No

Obstetrics/Gynecology (if applicable):

List number of pregnancies: _____ Number of live births: _____

Date of last period: _____ Age at menopause: _____

Do you currently have any problems with painful, irregular, or heavy periods? Yes No

Any history of abnormal PAP tests? Yes No

Social History:

Tobacco Use: Check one of the following:

___ Current smoker; packs per day: _____

___ Previous smoker: Years smoked: _____; Year quit: _____

___ Nonsmoker/never smoked

Alcohol Use: _____ drinks per week

Do you have any concerns with your alcohol use? (Binge drinking; drinking too much?) Yes No

Recreational drug use? Marijuana: Yes No Other: Yes No (specify)

Employment/Occupation: _____

Family History:

Do any of your "first degree" blood relatives (parents, siblings, children) have: Diabetes? Heart disease? (Heart attack, bypass surgery, stents, etc) Cancer? (Breast, colon, other)
High blood pressure? High cholesterol? Osteoporosis? Other significant health problems? (Circle any that apply and specify relative and specific condition)

Gender/Sexual Identity

1. What is your current gender identity? (Check ALL that apply)

☐ Male

☐ Female

☐ Transgender Male/Transman/FTM

☐ Transgender Female/Transwoman/MTF

☐ Gender Queer

☐ Additional category (please specify): _____

☐ Decline to answer

2. What sex were you assigned at birth? (Check one)

☐ Male

☐ Female

☐ Other

☐ Decline to answer

3. What pronouns do you prefer that we use when talking about you? (check all that apply)

☐ She/her/hers

☐ He/him/his

☐ They/them/theirs

☐ Other: Please specify: _____

4. Do you identify as: (check all that apply)

☐ Straight

☐ Gay

☐ Lesbian

☐ Bisexual

☐ Other: _____

5. Please describe your sexual activity during the last year (check all that apply):

☐ I was in a monogamous relationship with a man. (I had sex with one man only)

☐ I was in a monogamous relationship with a woman. (I had sex with only one woman)

☐ I had multiple male partners.

☐ I had multiple female partners.

☐ I had both male and female partners.

☐ I did not have any sexual partners.

☐ Other: _____

☐6. Please describe your current relationship status (check all that apply):

☐ Single

☐ Married

☐ In a civil union

☐ In a domestic partnership, living together

☐ Partnered, not living together

☐ Divorced

☐ Widowed

☐In a committed relationship ☐ Other:_____