

What medicines (prescription and over-the-counter), vitamins, supplements and/or herbs do you take regularly? None

Name	Dose	When do you take it?	What is it for?

Do you often have trouble remembering to take medicines? Yes No

Have you ever gotten a period? unsure Yes No
(skip to next section)

How old were you when you first got your period? _____

What was the date that your last normal period began? _____

What are your periods like?

I get one every _____ days.

It lasts for _____ days.

On my heaviest day, I use _____ maxi pads/tampons.

I get cramps with my period: Yes No

If yes, how severe are they on a scale of 1 (low) to 10 (high)? _____

Have you gone through menopause? unsure Yes No
(skip to next section)

At what age? _____

Have you had any bleeding since then? Yes No

Have you ever taken hormone replacement? Yes No

Do you currently take hormone replacement? Yes No

If yes, what do you take?

Estrogen/progesterone Estrogen alone

Testosterone Other: _____

Are you having any symptoms of menopause? Yes No

If yes, which ones? Hot flashes Mood changes

Vaginal dryness Insomnia

other: _____

When was your last vaccine for:	date
HPV (Gardasil)	
Tetanus / TdaP	
Hepatitis A	
Hepatitis B	
Pneumonia (pneumovax)	
Chicken pox (varavax)	
Shingles (zostavax)	

Did you receive childhood vaccinations? No I'm not sure Yes

Date: _____

Name _____

Birthdate _____

Chart No. _____

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When was the last time you had a test for tuberculosis (TB)? _____

Have you ever had a positive test for TB? Yes No

If yes, did you complete ≥ 6 months of preventative treatment?
 No Yes

If yes, which of the following symptoms do you have now? None

- cough > 3 weeks
- unexplained weight loss
- coughing up blood
- drenching night sweats

If no, have you had contact with someone known to have TB disease of the lung? Yes No

Were you born in Asia, Africa, Latin America, or Eastern Europe?
 Yes No

Have you spent more than 2 weeks in Asia, Africa, Latin America, or Eastern Europe in the past 2 years? Yes No

Have you been in prison/jail in the past 5 years? Yes No

Do you work with people who use drugs, are migrant workers, or are experiencing homelessness? Yes No

Are you a health care worker? Yes No

When was your last:	Date	Result
HIV test		
Sexually transmitted infection test		
Hepatitis C test		
Bone density test		
Cholesterol test		

- unsure never
- unsure never
- unsure never
- unsure never
- unsure never

When was your last:	Date	Result
Cervical Pap smear		
Was it ever abnormal?		<input type="checkbox"/> Yes
Anal Pap smear		
Was it ever abnormal?		<input type="checkbox"/> Yes
Mammogram		
Was it ever abnormal?		<input type="checkbox"/> Yes
Colorectal cancer		
Was it ever abnormal?		<input type="checkbox"/> Yes

- unsure never
- unsure never
- unsure never
- unsure never
- unsure never
- unsure never
- unsure never
- unsure never

Which test(s) you've had: FOBT FIT Colonoscopy Other

When was the last time you saw a dentist? _____

How often in the past year have you had an alcoholic beverage?

- Daily or almost daily
- Weekly
- Monthly
- Less than monthly
- Never

How often in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?

- Daily or almost daily
- Weekly
- Monthly
- Less than monthly
- Never

Have you ever had sex with another person? Yes No
(skip to next section)

In your lifetime your sexual partner(s) have been: (check all that apply)
 women transgender FTM genderqueer
 men transgender MTF other: _____

Currently your sexual partner(s) are: (check all that apply) none
 women transgender FTM genderqueer
 men transgender MTF other: _____

When was the last time you had sex with another person? _____

In the past year, how many different sexual partner(s) have you had? _____

Currently, how many sexual partner(s) do you have? _____

Do you only have sex with each other? No Yes
Are you practicing "safer sex"? Never Sometimes Always

Do you think you or your sexual partner(s) may have a sexually transmitted infection right now? Yes No

Are you having any difficulties with your sex life? Yes No

Do you want to discuss this today? Yes No

What sexually transmitted infection(s) have you had in the past? None
 Gonorrhea Oral herpes
 Chlamydia Genital herpes
 Pelvic inflammatory disease Herpes through a blood test
 Syphilis Genital warts
 Trichomonas Other: _____

Have you ever been pregnant? Yes No
If yes, how many times have you been pregnant? _____
How many abortions? _____ How many premature births? _____
How many miscarriages? _____ How many full-term births? _____
How many live children do you have now? _____

Are you planning on getting pregnant? Yes No
If yes, when? _____

Do you or your partner(s) use any kind of birth control? No Yes
If yes, what kind? _____ Not needed
Are you satisfied with this method? No Yes

Could you or your partner(s) be pregnant today? Yes No
What would you do if you or your partner(s) got pregnant? N/A

Have you ever been non-consensually hit, slapped, kicked, or otherwise physically hurt by an intimate partner? Yes No
If yes, when did this happen? _____
Do you want to discuss this today? Yes No

Have you ever been forced to have sexual activities against your will? Yes No
If yes, when did this happen? _____
Do you want to discuss this today? Yes No

Date: _____

new patient forms

Name _____

Birthdate _____

Chart No. _____