



New Patient Paperwork

Legal Name: _____ Preferred Name: _____

Preferred pronouns (circle one): She/her He/him They/them Other

DOB: _____ Social Security Number: _____ - _____ - _____

Mailing Address: _____

Phone number: _____ Can we text you? Yes No

Email address: _____ Can we email you? Yes No

Who referred you to us? _____

What is the purpose of your visit today? Circle One

Wellness Exam Routine STI Testing STI Testing/Symptoms Birth Control

HIV PEP/PrEP Menopause Therapy Menstrual Concern Other

Please list any allergies to medications: _____

Please list any medications you are currently taking (or attach list):

Drug	Dose	Frequency	Indication	Last taken
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_____	_____	_____	_____	_____
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_____	_____	_____	_____	_____
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_____	_____	_____	_____	_____
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_____	_____	_____	_____	_____
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Past Medical History

Please check if you have ever had any of the following:

- | | |
|---------------------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Hyperthyroid |
| <input type="checkbox"/> Blood clots/clotting disorders | <input type="checkbox"/> Epilepsy or seizures |
| <input type="checkbox"/> Pulmonary embolism | <input type="checkbox"/> Valvular heart disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> History of bariatric surgery |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Ulcerative colitis or Crohn's disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Ischemic heart disease | <input type="checkbox"/> Unexplained vaginal bleeding |
| <input type="checkbox"/> Peripartum cardiomyopathy | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Sickle cell disease | <input type="checkbox"/> Cervical cancer |
| <input type="checkbox"/> Gallbladder problems | <input type="checkbox"/> Chronic kidney disease |
| <input type="checkbox"/> Liver problems | <input type="checkbox"/> Depression/anxiety |
| <input type="checkbox"/> Breast disease | <input type="checkbox"/> Mood disorders |
| <input type="checkbox"/> Solid organ transplantation | <input type="checkbox"/> Schizophrenia or psychosis |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Gonorrhea/chlamydia |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> HIV |

Please list any previous surgeries:

Social History

Do you use nicotine? Yes No What type? cigarettes/cigars vape smokeless

Frequency of use: _____

Do you want to quit? Yes I'm thinking about it No

Do you use alcohol? Yes No If yes, how often? _____

Do you use recreational drugs? Yes No If yes, what type? _____

Frequency of use: _____

Do you exchange sex for drugs or money? Yes No

Sexual Health History

Are you sexually active? Yes No If no, skip to the next page

Do you have sex with partners that have Penises Vaginas Both

Please circle each type of sex you have engaged in in the past year:

Vaginal Anal insertive Anal receptive Oral

Do you use condoms (circle one): Always Usually Sometimes Rarely Never

How many sexual partners have you had in the last three months? _____

Of those partners listed above, how many of them were new? _____

When did you last have sex? _____ Was that with a new partner? Yes No

Did you use condoms? Yes No Do you have a concern for pregnancy? Yes No

Have you had a known exposure to any sexually transmitted infections (STIs)? Yes No

If yes, what were you exposed to? _____ When? ____ / ____ / ____

If you are having symptoms today, please describe: _____

Contraceptive History

What is your current method of birth control?

- | | |
|---------------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> The pill (combined hormonal) | <input type="checkbox"/> Withdrawal |
| <input type="checkbox"/> The patch | <input type="checkbox"/> Condoms |
| <input type="checkbox"/> The ring | <input type="checkbox"/> Diaphragm/spermicide |
| <input type="checkbox"/> The progestin-only pill | <input type="checkbox"/> Male relying on female method |
| <input type="checkbox"/> The depo shot | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> The hormonal IUD | <input type="checkbox"/> Menopausal |
| <input type="checkbox"/> The copper IUD | <input type="checkbox"/> Post-hysterectomy status |
| <input type="checkbox"/> The Nexplanon implant | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> The fertility awareness method | <input type="checkbox"/> Abstinence |

Please check each type of birth control you have used previously:

- | | |
|----------------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> I have never used birth control | <input type="checkbox"/> The progestin-only pill |
| <input type="checkbox"/> I have only used condoms | <input type="checkbox"/> The depo shot |
| <input type="checkbox"/> The pill (combined hormonal) | <input type="checkbox"/> The hormonal IUD |
| <input type="checkbox"/> The patch | <input type="checkbox"/> The copper IUD |
| <input type="checkbox"/> The ring | <input type="checkbox"/> The Nexplanon implant |

Of your previously used birth control methods, please describe why the method(s) were discontinued and how long they were used for:

Menstrual History

Today, which statement **best** describes your menstrual cycle?

____ I'm having regular periods. The date of my last period was: ____ / ____ / ____

____ My periods are irregular. The date of my last period was: ____ / ____ / ____

If your periods are irregular, please describe your cycles:

____ I'm pregnant, or my last pregnancy ended within the last two months, or I'm breastfeeding

____ My periods have stopped on their own (I've had menopause).

____ I've had menopause, but now have periods because I am taking hormones.

____ I've had a surgery which stopped my periods

If your periods stopped because of surgery, what did you have removed?

____ One ovary only

____ Uterus and one ovary

____ Both ovaries

____ Uterus and both ovaries

____ Uterus only

____ I don't know

____ I've taken medication or have an IUD/implant which has stopped my periods.

Please list the medication: _____

If you are having periods, is the flow (circle one): Light Moderate Heavy

Do you have painful periods? Yes No

If yes, is the pain controlled with over-the-counter pain medication? Yes No

Do you find yourself unable to perform daily activities due to painful periods? Yes No

Do you grow more hair than is considered normal on your face, chest, or back? Yes No

Obstetric History

Total number of pregnancies: _____

Number of live births: _____

Number of miscarriages: _____

Number of terminations: _____

Pregnancy complications: _____

Health Maintenance Screening Test History

_____ Mammogram Date: ____ / ____ / ____ Abnormal? Yes No

_____ Colonoscopy Date: ____ / ____ / ____ Abnormal? Yes No

_____ Bone density Date: ____ / ____ / ____ Abnormal? Yes No

_____ Pap test Date: ____ / ____ / ____ Abnormal? Yes No

If history of abnormal pap, what were the results?

_____ NIL _____ ASC-US _____ LSIL _____ HSIL _____ HR HPV+

_____ AGC _____ ASC-H _____ Other _____ Unknown

Where was your last pap test performed? _____

Have you ever had a colposcopy? Yes No Date: ____ / ____ / ____

Abnormal? Yes No

Have you ever had a LEEP? Yes No Date: ____ / ____ / ____

Abnormal? Yes No