BALCONES
OBSTETRICS & GYNECOLOGY, PA

New Patient Intake Form

Please complete this brief history to assist me in providing you with the best care possible.
This form will be added to your medical record.

Name: _____ Preferred Name _____ Preferred Pronoun(i.e. she/he; her/him) _____

Date of Birth: 0 Who referred you? _____

Reason for visit: _____

Sexuality/Gender Identity

What is your sexual orientation?
- ☐ Straight/Heterosexual
- ☐ Lesbian/Gay
- ☐ Bisexual
- ☐ Other _____
- ☐ Decline to state

What sex were you assigned at birth?
- ☐ Female
- ☐ Male
- ☐ Decline to state

What is your gender identity?
- ☐ Female
- ☐ Transgender woman/Transwoman
- ☐ Male
- ☐ Transgender man/Transman
- ☐ Gender queer/Gender non -conforming
- ☐ Decline to state

Recent Exam

Type of exam	Date of last exam	Location of exam
Pap test		
Mammogram		
Colonoscopy		
Pelvic/Transvaginal ultrasound		
Bone density study		

Gynecologic History

Date of last menstrual period: _____

Age (years) at 1st period _____; My period usually occurs every_____ days and lasts for _____days; Age at Menopause_____

Do you have a history of (If yes please provide date and describe):

- ☐ Ovarian cysts _____
- ☐ Fibroids _____
- ☐ Abnormal Pap test _____
- ☐ Sexually Transmitted Infection _____

Have you ever used oral contraceptives (if so for how many years)? _____

Have you ever used hormone replacement therapy (if so for how many years)? _____

Are you sexually active? ☐ No ☐ Yes Any problems? _____

Total number of pregnancies _____

# of Vaginal deliveries ___; Cesarean sections ___; Miscarriages ___; Abortions ___; Ectopic pregnancies ___;

Pregnancy Complications_____

Current Medications (include vitamins, herbs and other supplements)

Please review your attached medication list. Please add/remove medications based on what you currently take.

Name of Medication	Dosage	How Often

Allergies

Are you allergic to any medications? ☐ No ☐ Yes (Please specify the medication and reaction):

Medical History (either now or in the past/detail below with year of diagnosis and treatment given)

- ☐ Asthma
- ☐ Cancer
- ☐ Cardiac disease
- ☐ Diabetes
- ☐ Hypertension / high blood pressure
- ☐ Hyperlipidemia / cholesterol
- ☐ Irritable bowel syndrome
- ☐ Inflammatory bowel disease
- ☐ Lupus
- ☐ Osteoporosis / osteopenia
- ☐ Stroke
- ☐ Thrombotic disorder (blood clots)
- ☐ Thyroid disease (low / high)
- ☐ Reflux (GERD)

Psychiatric diagnosis
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar disorder
- ☐ Other: _____

_____

_____

Name: _____ Date of visit: _____

Surgical History

Name of Procedure	Date of Procedure	Reason for Procedure

Family History

Do you have a family member with any of the following cancers (if yes please list which family member and age of diagnosis)

- ☐ Breast cancer _____
- ☐ Ovarian cancer _____
- ☐ Uterine/endometrial cancer _____
- ☐ Prostate cancer _____
- ☐ Pancreatic cancer _____
- ☐ Colon cancer _____
- ☐ Melanoma _____
- ☐ Other cancer (specify) _____

Mother: ☐ Living ☐ Deceased (cause) _____

Father: ☐ Living ☐ Deceased (cause) _____

Siblings: Number living: _____ Number deceased: _____ Cause: _____

Social History

Do you exercise? If so what do you do _____

Occupation_____ Marital Status_____

Do you smoke? _____ How many packs a day? _____ If you quit, when was this? _____

Do you drink alcohol? _____ How many drinks per week? _____ Any other drugs? _____ Which other drugs?_ _____

Review of Systems: Are you experiencing any of the following symptoms?					
Constitutional	☐ No	☐ Weight loss	☐ Weight gain	☐ Fever	☐ Fatigue
Eye Problems	☐ No	☐ Vision Changes	☐ Glasses	☐ Contacts	☐ Other
Ear, Nose, Throat	☐ No	☐ Ulcers	☐ Sinusitis	☐ Headache	☐ Hearing Problems
Cardiovascular	☐ No	☐ Chest pain	☐ Leg Swelling	☐ Palpitations	☐ Other
Respiratory	☐ No	☐ Wheezing	☐ Cough	☐ Shortness of Breath	☐ Other
Gastrointestinal	☐ No	☐ Diarrhea	☐ Constipation	☐ Nausea	☐ Vomiting
Urinary	☐ No	☐ Painful Urination	☐ Urgency	☐ Frequency	☐ Bloody Urine
Skin/Breast	☐ No	☐ Breast Pain	☐ Nipple discharge	☐ Breast Mass	☐ Skin Rash
Neurological	☐ No	☐ Fainting	☐ Seizures	☐ Numbness	☐ Trouble Walking
Psychiatric	☐ No	☐ Depression	☐ Anxiety	☐ Other	
Blood/Lymph	☐ No	☐ Easy Bruising	☐ Abnormal Bleeding	☐ Swollen Glands	☐ Other
Musculoskeletal	☐ No	☐ Weakness	☐ Pain	☐ Other	

Physicians

Medical / primary care physician: _____ Phone #_____

Obstetrician / Gynecologist: _____ Phone # _____

Cardiologist: _____ Phone # _____

Other physician: _____ Phone # _____

Other physician: _____ Phone # _____