Eastside Women's Health Center **New Patient/Initial Intake Form**

Legal Name* : Birth Date: Preferred Name:	Allergies: e-mail address:	
Legal Sex (please circle one)* Female Male **While EWHC recognizes a number of genders/sexes; many insurance companies and legal entities unfortunately, do not. Please be aware that the name and sex you have listed on your insurance must be used on the documents pertaining to insurance, billing and correspondence. If your preferred name and pronouns are different from these, please let us know.*	Age:	Preferred pronouns:
Reason for today's Visit:	Your Primary Care Provider:	
Marital Status:	Your occupation:	

Menstrual History

Age when period first started: First day of last period:
# of days you bleed: # of days between periods:
Any problems with period? Y N Amount of bleeding: Heavy Medium Light

Sexual History

I have sex with (circle one): Men Women Both Bi-Sexual partners Trans/Queergender partners Not active
Age at first intercourse: Date of last pap smear? Last abnormal pap:
I have had or my partner has had a new partner in the last year: Yes No Not active
Do you have any bleeding or pain with sexual activity? Yes No
How do you protect yourself from sexual transmitted infections?

Pregnancy History

# of full term pregnancies: # of premature pregnancies: # of vaginal births:
# of c-sections: # of miscarriages: # of abortions: # of ectopic preg.:
# of living children: Ages of children: # of children placed for adoption:
# of children adopted:

Contraceptive History

Current method of birth control: Problems with it? Yes No
Other methods used in past: Want to changing methods? Yes No

Menopause and Beyond

Age you stopped having periods: Problems or concerns? Yes No
Taking hormone therapy (HT)? Yes No

Gynecological/Medical/Surgical History- check if you have or have had

☐ Abnormal uterine bleeding	☐Pelvic Pain	☐Abnormal pap smear/treatment
☐Fibroids	☐Endometriosis	☐Warts/Herpes
☐Ovarian cysts or tumors	☐Premenstrual syndrome	☐Pelvic Infection
☐Loss of urine or feces	☐ Vaginitis (yeast, BV, trich)	☐Chlamydia/Gonorrhea

☐Infertility issues ☐Herpes ☐Breast/Chest Pain/Discharge

Health & Nutrition

I exercise _______ times a week. What type of exercise do you do?______________________________
I take calcium. Yes No How much? _________ I take vitamin D. Yes No How much? _______
Amount of drink in a week: alcohol ______ tea ______ coffee ______
Do you smoke? Yes No If yes, how much? _______________
Do you use street drugs? Yes No If yes, what kind and how often?

Describe your diet.

Medical and Family History ☐**I have no knowledge of my family history.**

Check if YES:	Self (S)	Family (F)	Check if YES:	S	F	Check if YES:	S	F
Breast cancer			High cholesterol			Skin problems		
Insomnia			Muscle/joint pain			Vision problems		
Ovarian cancer			High blood pressure			Jaundice/hepatitis		
Colon cancer			Blood clots lungs/legs			Asthma		
Uterine cancer			Thyroid problems			HIV/AIDS		
Other cancer			Lung problems			Anemia		
Diabetes			Breast problems			Birth defects		
Heart disease			Colon/Stool problems			Varicose Veins		
Rheumatic fever			Reflux/ulcer			Migraines		
Stroke			Stomach problem			Headaches not migraines		
Osteoporosis/Fracture			Gall bladder problem			Seizure/epilepsy		
Shortness of Breath/Chest Pain			Kidney/bladder problem			Depression		
Arthritis/joint pain			Urine infections			Anxiety		

List any hospitalizations, surgeries, accidents or serious illness and their year.

Please list any medications, herbs, vitamins, and supplements you are taking:

Prevention

Because it is so common and we are concerned about your safety, we ask all patients about the presence of violence in their home and relationships. We want you to be safe, and we can help. Are you being:

☐Hurt ☐Threatened with physical harm
☐Insulted or talked down to ☐I have a history of sexual/physical abuse.
☐Screamed at or cursed

To the best of my knowledge, the questions on this form have been answered correctly.

____
Patient Signature Date

I have read and reviewed the information provided by the patient/guardian above.

Provider Name and Signature Date