KAMM MCKENZIE OBGYN

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NEW PATIENT INTAKE FORM

Please fill out this form completely. This is a confidential record of your medical information.

Patient Name: _____ **Preferred Name:** _____

DOB: _____ **Preferred Pronouns** (circle one): She/Her He/Him They/Their Other

What is the reason for your visit today?_____

_____

PAST MEDICAL HISTORY- Check if you have ever had any of the following conditions.

- ADD/ADHD
- Addiction
  - Type: _____
- Allergies
- Anemia
- Anxiety
- Arthritis
  - Type: _____
- Asthma
- Breast Disease
- Cancer
  - Type: _____
- Depression
- Diabetes
- Eating Disorder
  - Type: _____
- Gallbladder Problems
- GI Disorder
  - Type: _____
- Headaches
  - Type: _____
- Heart Disease
- Hepatitis
- High Blood Pressure
- High Cholesterol
- Infertility
- Kidney Stones
- Osteopenia
- Osteoporosis
- Other Mental Health
  - Type: _____
- Ovarian Cyst
- Overactive Bladder
- Premenstrual Syndrome
- Pneumonia
- Polycystic Ovarian Syndrome
- Rubella
- Seizures
- Sexually Transmitted Infection
  - Type: _____
- Stroke
- Thyroid Disorder
- Varicose Veins
- Victim of Abuse
- Other: _____

MEDICATIONS- Please list all medications you are currently taking, including dose and frequency.

_____ _____ _____

_____ _____ _____

_____ _____ _____

SUPPLEMENTS- Please list all supplements you are currently taking, including dose and frequency.

_____ _____ _____

_____ _____ _____

ALLERGIES

Are you allergic to any medications (circle one)? No Yes If yes, name of drug and reaction:

_____

SURGICAL HISTORY- Please list any prior surgeries and dates.

_____ _____

_____ _____

_____ _____

PREVENTATIVE HEALTH SCREENINGS- Please list the date/results of your most recent screenings, if applicable.

- Pap Smear _____
- Mammogram _____
- Colonoscopy _____
- Bone Density _____

FAMILY HISTORY- List any 1st or 2nd degree relative and AGE at diagnosis, with the following conditions:

- Breast Cancer _____
- Colon Cancer _____
- Diabetes _____
- Heart Disease _____
- High Blood Pressure _____
- Ovarian Cancer _____
- Pancreatic Cancer _____
- Prostate Cancer _____
- Thyroid Disease _____
- Other Condition _____

SEXUAL HEALTH / REPRODUCTIVE HISTORY

GYN HISTORY:

- Age at time of *first* menstrual period: _____ If menopausal, age at time of *last* period: _____
- How often do your periods occur, from the <u>first</u> day of your menstrual period, to the <u>first</u> day of your NEXT menstrual period? _____ How many days do your periods last? _____
- Are your periods typically (circle one): Light Medium Heavy
    - Do you pass clots (circle)? Yes No

- How many pads or tampons do you use PER DAY? _____

- **1st day** of your last menstrual period: _____ Are you certain of this date (circle)? Yes No
- Have you taken a home pregnancy test since your last menstrual period (circle)? Yes No
  - Result: _____
- Are you currently sexually active (circle)? Yes No
  - If YES, is your Partner (circle all that apply): Male Female Other Gender Identity
- Are you currently using any method of pregnancy prevention (circle)? Yes No
  - If YES, what method? _____
- Are you currently trying to conceive (circle)? Yes No
- Have you ever had an ABNORMAL Pap Smear (circle)? Yes No
  - If YES, list date(s), results, and treatments :_____
- Have you received the GARDASIL (HPV) Vaccine series (circle)? Yes No Incomplete

REPRODUCTIVE HISTORY:

- **Total number of prior pregnancies** (*including* any miscarriages, ectopics, or abortions): _____
- Number of: (1) **Full Term** deliveries (> 37 weeks): _____ (2) **Preterm** deliveries (< 37 weeks): _____
- Number of: Miscarriages: _____ Ectopic Pregnancies: _____ Elective Abortions: _____
- Pregnancy with multiples (ie-twins)?_____Number of Living Children: _____Adopted Children: _____

PREGNANCY DETAILS:

*Please document all prior pregnancies, including miscarriages, elective abortions, and ectopic pregnancies.

Date	Gestation	Hours in labor	Birth weight	Male/Female	Vaginal or C-section	Anesthesia type	Complications	Delivering MD

SOCIAL HISTORY

- MARITAL STATUS (circle one): Single Engaged Married Divorced Separated Widowed
- Occupation: _____
- Do you Exercise (circle one)?: Yes No - Type /Frequency: _____
- Alcohol Intake- Number of drinks per week: _____ Type: _____
- Tobacco Use (circle one): Never Former Current - If FORMER: Date Quit: _____
    - If CURRENT, Number of packs per day: _____ For how many years? _____
- Marijuana Use (circle one): Never Sometimes Regularly
- Illicit Drugs (circle one): Never Former Current
    - If CURRENT, Type/Frequency of use: _____

DOMESTIC VIOLENCE SCREENING:

- Have you ever been the victim of any form of Domestic Abuse (circle all that apply)?:

  Sexual Abuse Physical Abuse Emotional Abuse Verbal Abuse No History of Abuse
    - If YES, list dates: _____ Are you safe now (circle one)? Yes No

DEPRESSION SCREENING: **THE PATIENT HEALTH QUESTIONNAIRE-2**

Over the past 2 weeks, how often have you been bothered by any of the following problems? (circle one)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

Patient Signature: _____ **Date:** _____

Legal Guardian (if minor): _____