NEW PATIENT FORM DATE_____

Legal First Name: _____**Last Name**: _____

Preferred or Nick Name: _____ **Date of birth:** _____

Street Address: _____

City: _____**State:** _____ **Zip:** _____ **Soc. Sec. #**:_____

Home Phone #:_____ **Mobile #**: _____

Email Address: _____

Ethnicity: ____ Hispanic/Latino **Race:(check all that apply)**

____ Not Hispanic/Latino ____ Black/African-American ____ White

____ American Indian or Alaska Native ____ Asian

____ Native Hawaiian or other Pacific Islander ____ Other_____

Sex Assigned at Birth: _____Male _____Female _____Intersex

Current Gender Identity: ____Male ____Female ____Transgender Male (FTM)

____Transgender Female (MTF) ____Non-binary ____Other ____Choose not to disclose

Preferred Pronouns: ____He/his/him ____She/hers/her ____They/Their/Them

Sexual Orientation: ____Straight (heterosexual) ____Lesbian/Gay (Homosexual) ____Bisexual

____Other ____Choose not to disclose

Marital Status: ____ Single ____Married ____Partnered ____Divorced ____Widowed ____Separated

Emergency Contact Name: _____ **Contact Phone**: _____

Primary Pharmacy Name:_____

Address:_____

Phone:_____

Secondary Pharmacy Name:_____

(or Mail order) Address:_____

Phone:_____

Insurance: Do you have insurance? ____No ____Yes (if yes, complete below)

Guarantor: ____ Self ___ Spouse ____ Parent ____ Other:_____

Primary Plan Name: _____ Effective Date: _____

Insurance ID: _____ Group ID: _____

If guarantor other than self: Guarantor Name: _____

Guarantor Date of birth: _____ Phone Number:_____

Secondary Plan Name_____ Insurance ID:_____

MEDICAL HISTORY

Medication Allergies/Sensitivities

☐ No Significant Allergies

	Medications	Reaction		Others	Reaction
1.			2.		
3.			4.		
5.			6.		
7.			8.		
9.			10.		

Current Medications

☐ No Known Current Medication

	Medication Name		Medication Name
1.		2.	
3.		4.	
5.		6.	
7.		8.	
9.		10.	

Please enter additional Current Medication details if any:

Surgical History

☐ No Significant Past Surgical History

Surgery	Year	Surgery	Year	Surgery	Year
☐ Appendectomy		☐ CABG		☐ Cholecystectomy	
☐ Colposcopy		☐ Gastric Bypass		☐ Hysterectomy	
☐ Sinus Surgery		☐ Tonsillectomy		☐ Transgender Top Surgery	
☐ Transgender Bottom Surgery					

Please enter additional Surgical History details if any:

Past Medical History

☐ **No Significant Past Medical History**

☐ Abnormal breast exam or mammogram	☐ Abnormal PAP smear	☐ ADHD	☐ Anemia
☐ Anxiety	☐ Arrhythmia (or other irregular heartbeat)	☐ Arthritis	☐ Asthma
☐ Atopic dermatitis	☐ Atrial fibrillation	☐ Bipolar disorder	☐ Bleeding disorders
☐ Blood transfusion	☐ Broken bone	☐ C. difficile diarrhea	☐ Cancer, Breast
☐ Cancer, Colon	☐ Cancer, Prostate	☐ Cancer Other: specify	☐ Congestive heart failure
☐ COPD/Emphysema	☐ Coronary artery disease	☐ Crohn's/Ulcerative colitis	☐ Deep vein thrombosis or pulmonary embolus (clots)
☐ Depression	☐ Diabetes type I	☐ Diabetes type II	☐ ENT (ear, nose, throat) disorder
☐ Epilepsy (seizure disorder)	☐ Esophageal varices	☐ Gastric ulcer	☐ GERD (acid reflux)
☐ Gout	☐ Heart attack	☐ Heart disease	☐ HIV/AIDS
☐ Hyperlipidemia (high cholesterol)	☐ Hypertension (high BP)	☐ Hypotension (low BP)	☐ Irritable bowel disease (IBS)
☐ Kidney disease	☐ Kidney stones	☐ Liver disease	☐ Low white blood cells
☐ Lung disease	☐ Migraines/Chronic headaches	☐ Myocardial infarction	☐ Pancreatitis
☐ Panic attacks	☐ Peripheral vascular disease	☐ Prostate (abnormal)	☐ Psychiatric/Mental health diagnoses: specify:
☐ Sleep Apnea	☐ Stroke	☐ Thyroid (abnormal)	☐ Urinary tract infections (chronic)

Past Infectious Disease History (please check all that apply):

☐ Amoeba diarrhea	☐ Chlamydia-anal	☐ Chlamydia-genital	☐ Chlamydia-oral
☐ Giardia diarrhea	☐ Gonorrhea-anal	☐ Gonorrhea-genital	☐ Gonorrhea-oral
☐ Hepatitis A	☐ Hepatitis B	☐ Hepatitis C	☐ Herpes: specify body site
☐ HIV/AIDS (see below if yes)	☐ HPV (warts)	☐ Lice ("crabs")	☐ MRSA: specify body site
☐ Scabies	☐ Shingles	☐ Syphilis	☐ Trichomoniasis

HIV / AIDS History:

If HIV negative, when was your last HIV test?

If you are diagnosed HIV positive, please answer the below:

HIV diagnosis date:		City and State where HIV first diagnosed:	
Have you received an AIDS diagnosis?	○ Yes ○ No	Date of AIDS diagnosis:	
Latest T-cell (CD4) count:	Date:	Latest viral load:	Date:
Current HIV provider:			
If HIV positive, are you currently case managed?	○ Yes ○ No		
If yes, name of case management agency:		Name of case manager:	

Please enter additional Past Medical History details if any:

Hospitalizations:

If you have ever been hospitalized, please provide the details of hospitalization (includes childhood illness).

#	Treated For	When	Where	#	Treated For	When	Where
1.				2.			
3.				4.			

5.				6.			

Immunization History:

Please select your answer and specify the year.

Immunization/Vaccine	Answer	Year	Immunization/Vaccine	Answer	Year
Flu vaccine within last year I would like to receive Flu vaccine today	Yes No Unknown Yes No		Hepatitis A vaccine	Yes No Unknown	
Adult Pneumovax-23 I would like to receive Pneumovax today	Yes No Unknown Yes No		Hepatitis B vaccine Series of 3	Yes No Unknown	1) 2) 3)
Adult Prevnar-13 I would like to receive Prevnar-13 today	Yes No Unknown Yes No		TwinRix Vaccine (Hep A and B combo) Series of 3	Yes No Unknown	1) 2) 3)
Tetanus/Tdap	Never Unknown < 10 years > 10 years		Tuberculosis/PPD	Yes No Unknown	
HPV (Gardasil)	Yes No Unknown		Previous POSITIVE PPD result	Yes No	
Zoster (shingles) vaccine	Yes No Unknown		Previous NEGATIVE Chest X-ray result	Yes No	

Preventive Health Screenings:

Screening	Date	Screening	Date
Last PSA (men)		Last Oral Cancer Screen	
Last Rectal/Prostate (men)		Last Bone Density Screen	
Last Colonoscopy or Sigmoidoscopy		Positive Occult Blood (stool)	
Stool test for blood		Last Anal PAP	○ Negative ○ Positive
Last Dental Exam		Other	

Gynecologic and Obstetric History (if applicable)

Please answer the below if appropriate.

Your age at onset of menstruation:		Date of your last period:	
Are you:	○ Premenopausal ○ Perimenopausal ○ Postmenopausal		
Have you ever had a mammogram?	○ Yes ○ No	If yes, when was your most recent?	
Was your mammogram ever abnormal?	○ No ○ Yes		
Have you ever had a Pap test?	○ Yes ○ No	If yes, when was your most recent?	
Was your Pap ever abnormal?	○ No ○ Yes	Have you ever had HPV?	○ Yes ○ No
How many pregnancies have you had?		Are you currently pregnant?	○ No ○ Yes

Substance Use History:

Please check all that apply.

Smoking Status
○ Current every day smoker ○ Current some day smoker ○ Former smoker ○ Never smoker
○ Smoker, current status unknown ○ Unknown if ever smoked ○ Heavy tobacco smoker ○ Light tobacco smoker

	Check One	How much/How often	Last Use	Quit Date	Request info on quitting
Tobacco	○ No ○ Yes				○ Yes ○ No
Alcohol	○ No ○ Yes				○ Yes ○ No
Recreational Drugs	○ No ○ Yes				○ Yes ○ No

Prescription Narcotics Type:	○ No ○ Yes				○ Yes ○ No
Ever received treatment for any of the above?	○ Yes ○ No	When?			

Sexual Orientation:

If sexually active, do you have sex with: ☐ Men ☐ Women ☐ Transmen ☐ Transwomen ☐ N/A

Please enter additional Social History details if any:

Family History

☐ **No Known Family History**

☐ **Adopted**

Problems	**Relation** (list one or more)	**Problems**	**Relation** (list one or more)
☐ Hypertension		☐ Hyperlipidemia	
☐ Diabetes		☐ Heart Disease	
☐ Stroke		☐ Psychiatric Disorder	
☐ Cancer			

Please enter additional Family History details if any:

Review Of Systems

Constitutional Symptoms

Appearance	○ Normal ○ Abnormal	Disability	○ Denies ○ Reports
Fever	○ Denies ○ Reports	Chills	○ Denies ○ Reports
Malaise/Fatigue	○ Denies ○ Reports	Night sweats	○ Denies ○ Reports

Recent weight changes			
Comments			
Eyes			
Blurred vision	Denies Reports	Double vision	Denies Reports
Photophobia	Denies Reports	Visual changes	Denies Reports
Discharge	Denies Reports	Glaucoma	Denies Reports
Itching	Denies Reports	Lacrimation	Denies Reports
Pain	Denies Reports	Redness of eyes	Denies Reports
Eyeglasses	Denies Reports	Contact lens	Denies Reports
Comments			
Ears/Nose/Mouth/Throat			
Hearing loss	Denies Reports	Ear pain	Denies Reports
Sensation of the room spinning inside your body	Denies Reports	Tinnitus	Denies Reports
Nasal congestion	Denies Reports	Nasal discharge	Denies Reports
Abnormal sneezing	Denies Reports	Bleeding from nose	Denies Reports
Postnasal drip	Denies Reports	Oral ulcers	Denies Reports
Oro-dental problems	Denies Reports	Sore throat	Denies Reports
Sensation of a lump in the throat	Denies Reports	Swollen glands in neck	Denies Reports
Ulcerations	Denies Reports		
Comments			
Cardiovascular			
Chest pain	Denies Reports	Murmur	Denies Reports
Palpitation	Denies Reports	Claudication	Denies Reports
Dyspnea	Denies Reports	Orthopnea	Denies Reports
Edema	Denies Reports	Previous EKG	

Comments			
Respiratory			
Cough	Denies Reports	Shortness of breath	Denies Reports
Chest tightness	Denies Reports	Hemoptysis	Denies Reports
Asthma	Denies Reports	Wheezing	Denies Reports
Comments			
Gastrointestinal			
Nausea/Vomiting	Denies Reports	Change in bowel habits	Denies Reports
Diarrhea	Denies Reports	Constipation	Denies Reports
Abdominal pain	Denies Reports	Difficulty with swallowing	Denies Reports
Blood in stools	Denies Reports	Hemorrhoids	Denies Reports
Comments			
Genitourinary			
Blood in urine	Denies Reports	Painful urination	Denies Reports
Excessive nighttime urination	Denies Reports	Urinary frequency	Denies Reports
Hesitancy	Denies Reports	Urinary urgency	Denies Reports
Dribbling	Denies Reports	Decreased urine stream	Denies Reports
Abnormal discharge	Denies Reports	Burning	Denies Reports
Itching	Denies Reports	Dyspareunia	Denies Reports
History of urinary tract/bladder/kidney infection	Denies Reports		
Comments			
Female GU			
LMP		Age at menarche	
Average cycle length		Shortest cycle length	
Longest cycle length		No. of pregnancies - live births	

No.of abortions		No.of miscarriages	
No.of stillbirths		Date of last PAP smear	
Painful menstruation	Denies Reports	Heavy periods	Denies Reports
Menstrual tension	Denies Reports	PMS	Denies Reports
Hot flashes/night sweats	Denies Reports	Recent breast tenderness/lumps	Denies Reports
Abnormal vaginal discharge	Denies Reports	Prior D and C	Denies Reports
C-section	Denies Reports	Hysterectomy	Denies Reports
Abnormal PAP smear	Denies Reports	Pregnancy	Denies Reports
Comments			
Male GU			
Lumps/pain in testicles	Denies Reports	Difficulty with erection/ejaculation	Denies Reports
Abnormal discharge from penis	Denies Reports	Date of last prostate exam	
Comments			
Musculoskeletal			
Joint pain	Denies Reports	Neck pain	Denies Reports
Shoulder pain	Denies Reports	Back pain	Denies Reports
Upper extremity pain	Denies Reports	Lower extremity pain	Denies Reports
Numbness/tingling sensations	Denies Reports		
Comments			
Integumentary			
Itching	Denies Reports	Rashes	Denies Reports
Change in skin color	Denies Reports	Change in hair/nails	Denies Reports
Varicose veins	Denies Reports		

Comments			
Neurological			
Seizures	Denies Reports	Headache	Denies Reports
Numbness	Denies Reports	Weakness	Denies Reports
Tremors	Denies Reports	Decrease in cognitive skills	Denies Reports
Loss of balance	Denies Reports	Head injury	Denies Reports
Paralysis	Denies Reports		
Comments			
Psychiatric			
Difficulty concentrating	Denies Reports	Insomnia	Denies Reports
Changes in socializing	Denies Reports	Irritability/ mood changes	Denies Reports
Suicidal thoughts/ attempts	Denies Reports	Anxiety	Denies Reports
Depression	Denies Reports	Nervousness	Denies Reports
Forgetfulness	Denies Reports	Adequate /sound sleep	Denies Reports
Previous use of psychotropic medication	Denies Reports		
Comments			
Endocrine			
Excessive urination	Denies Reports	Heat or cold intolerance	Denies Reports
Changes in hat/glove size	Denies Reports	Nocturia	Denies Reports

Glandular/ hormonal problem	Denies Reports	Excessively dry skin	Denies Reports
Comments			
Hematologic			
Anemia	Denies Reports	Easy bruising	Denies Reports
Night sweats	Denies Reports	Slow healing wounds	Denies Reports
Past transfusions	Denies Reports	Phlebitis	Denies Reports
Comments			
Please enter additional Review of Systems details if any:			

Thank you for completing the form. Please either email to us (info@DiversityHealthCenter.com), fax (813-518-0882) or bring with you to you new patient visit. Please call us to schedule that appointment if you haven't already done so at (813) 518-0881