Horizons OB-GYN & Aesthetics

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:_____Date of Birth:_____Today's Date:_____

Address: _____City_____Zipcode:_____

Phone Number: _____E-mail address: _____

Pharmacy name: _____ Address/phone #::_____

How did you hear about us? _____ Friends? Who?_____? ___Referral? Who?_____
____google _____insurance? _____social media?

Reason for Visit:_____

RECENT EXAM

TYPE OF EXAM	DATE OF LAST EXAM	RESULT
Pap Test		
Mammogram		
Colonoscopy		
Pelvic/Transvaginal Ultrasound		
Bone Density Study		

GYNECOLOGICAL HISTORY

Date of last menstrual period: _____

Age (years) at 1st period_____; My period usually occurs every ____ days and lasts for ____ days; Age at Menopause_____

Please check *Yes or No*

Heavy periods: ☐ No ☐ Yes Painful Periods: ☐ No ☐ Yes Irregular Bleeding: ☐ No ☐ Yes PMS (bloating,moody):☐ No ☐ Yes
Abnormal Pap Smears: ☐ No ☐ Yes (Year & Treatment Given)_____

Abnormal Mammograms: ☐ No ☐ Yes (Year & Treatment Given)_____

Have you ever had any of the following infections? (Please check all that apply)

☐ Gonorrhea ☐ Chlamydia ☐ Herpes ☐ Trichomonas ☐ Genital Warts/HPV ☐ Syphilis ☐ None

If so, when and how was it treated?_____

Have you had any of the following conditions? (Please check all that apply)

☐ Uterine Fibroids ☐ Infertility ☐ Ovarian Cysts ☐ Breast disease/biopsy ☐ Endometriosis ☐ None

If so, please detail the year and how it was treated?_____

Contraception/Pregnancy History

Sexually active: ☐ No ☐ Yes Medical issues pertaining to sexual activity: _____

Have you ever used contraceptives (if so, name and any issues)? _____

Total number of pregnancies: _____

# of Vaginal Deliveries _____; Cesarean sections_____; Miscarriages_____;Abortions_____;Ectopic____Living;_____

Pregnancy complications_____

Pregnancy History

Date	Delivery Type	Birth Weight	Gender/Name	Complications

Have you ever used Hormone Replacement Therapy? (If so, how many years)_____

CURRENT MEDICATIONS (include vitamins, herbs, and other supplements)

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: _____
_____
_____

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: _____

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

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:
□ Weight Loss
□ Weight gain
□ Fever
□ Fatigue

Eye Problems:
□ Vision Changes
□ Glasses
□ Contacts
□ Other

Ear, Nose, Throat:
□ Ulcers
□ Sinusitis
□ Headache
□Hearing Problems

Cardiovascular:
□ Chest Pain
□ Leg Swelling
□ Palpitations
□ Other

Respiratory:
□ Wheezing
□ Cough
□ Shortness of Breath
□ Other

Gastrointestinal:
□ Diarrhea
□ Constipation
□ Nausea
□ Vomiting

Urinary:
□ Painful Urination
□ Urgency
□ Frequency
□ Bloody Urine

Skin/Breast:
□ Breast Pain
□ Nipple discharge
□ Breast Mass
□ Skin Rash

Neurological:
□ Fainting
□ Seizures
□ Numbness
□ Trouble Walking

Psychiatric:
□ Depression
□ Anxiety
□ Other

Blood/Lymph:
□ Easy Bruising
□ Abnormal Bleeding
□ Swollen Glands
□ Other

Musculoskeletal:
□ Weakness
□ Pain
□ Other

PHYSICIANS

Medical/Primary Care Physician:_____Phone #_____

Other Physician: _____Phone #_____

EMERGENCY CONTACT

Name_____Phone #_____Relationship_____

Returning clients- Any changes since last visit? ▢ No ▢ Yes *If YES, please indicate changes on form.*

WHAT ARE YOUR TOP 3 SKINCARE CONCERNS:

1._____
2._____
3._____

PREVIOUS TREATMENTS:

Facials: ▢ No ▢ Yes Last Treatment_____Any complications?_____

Cosmetic Procedures:▢ No ▢ Yes Last Treatment_____Any complications?_____

Chemical Peels: ▢ No ▢ Yes Last Treatment_____Any complications? _____

Injectables: ▢ No ▢ Yes Last Treatment_____Any complications? _____

Hair Removal: ▢ No ▢ Yes Last Treatment_____Any complications? _____

Tanning: ▢ No ▢ Yes Last Treatment_____Any complications? _____

Laser Therapy: ▢ No ▢ Yes Last Treatment_____Any complications? _____

Light Therapy: ▢ No ▢ Yes Last Treatment_____Any complications? _____

Microcurrent: ▢ No ▢ Yes Last Treatment_____Any complications? _____

Other ▢ No ▢ Yes Last Treatment_____Any complications? _____

SKIN CONDITIONS: (*please check all items below that pertain to you)*

▢Skin Infection	▢Herpes	▢Keloids/Excessive Scarring
▢Skin cancer_____	▢Poor Healing	▢Tattoos/Permanent Makeup
▢Eczema/Psoriasis	▢Lymph Nodes Removed	▢Mold Exposure
▢Sun Sensitivity	▢Easy Bruising	▢Auto Immune Condition_____

SKINCARE: What type of skin do you feel you have? ▢Dry ▢Oily ▢Normal ▢Combination

What is your skin routine? (*Indicate any cleansers, toners, serums, moisturizers, masques, etc.)*

1._____ 4._____
2._____ 5._____
3._____ 6._____