# New Patient Intake

Name: Date of birth:

Is this your first visit with Dr. Rabin? ☐ Yes ☐ No

What is the **main problem** or purpose for your visit today?

Is this a: ☐ Problem Visit or a ☐ Well Visit?

Is this your annual gynecological exam? ☐ Yes ☐ No

When was the First Day of you last period? Periods are: ☐ Absent ☐ Regular ☐ Irregular ☐ Heavy ☐ Painful

When was your last pap smear? What were the results?

Have you ever had an abnormal pap result? ☐ Yes ☐ No explain

Any treatment for abnormal pap? ☐ Yes ☐ No If 'yes' ☐ Biopsy ☐ Freezing ☐ Laser ☐ Leep Other

When was your last mammogram? What were the results?

Ever had an abnormal mammogram result?

Any treatment for an abnormal mammo? ☐ Yes ☐ No Did you have: ☐ Biopsy ☐ Needle Aspiration ☐ Surgery Other:

When was your last colonoscopy: ☐ Never What were the results?

When was your last bone density test? Result: ☐ Normal ☐ Osteopenia ☐ Osteoporosis

How many pregnancies have you had?

How many were full term? How many live births? How many abortions?

How many miscarriages? How many were premature? Any complications?

Are you trying to avoid getting pregnant right now? ☐ Yes ☐ No

How do you avoid getting pregnant?

(Including pills, rings, patch, condoms, sponge, spermicide, foam, film, IUD, vasectomy, tubal ligation, not sexually active, lesbian, other)

Do you have any **drug allergies** or sensitivities? ☐ Yes ☐ No

List Medication and Reaction if known:

List all **medications** you're taking now:

List all **vitamins**, herbs, supplements you are taking:

Do you get more than 6 hours of uninterrupted sleep most nights? ☐ Yes ☐ No

Is it hard to fall asleep? ☐ Yes ☐ No Is it hard to stay asleep? ☐ Yes ☐ No

Have you had any significant weight changes in the past year? ☐ Yes ☐ No ☐ Gained ☐ Lost pounds

Have you had any significant weight changes in the past 5 years? ☐ Yes ☐ No ☐ Gained ☐ Lost pounds

Please list any **medical problems** or diagnoses (i.e. asthma, diabetes, high blood pressure):

What **surgeries** have you had?

Do you smoke: ☐ Yes ☐ No How many packs per day?

How many alcoholic drinks per week?

Do you use any recreational or non-prescribed drugs? ☐ Yes ☐ No Which drugs?

## Family History:

Do you or any of your close relatives have **breast, cervix or ovarian cancer**? ☐ Yes ☐ No

Do you or any of your close relatives need to be on blood thinners (clotting disorder)? ☐ Yes ☐ No

Do you or any of your close relatives have:

Heart disease? ☐ Yes ☐ No Colon cancer? ☐ Yes ☐ No Diabetes? ☐ Yes ☐ No

Any other family health history you'd like to share?

Select any that apply:

- [ ] **I am generally healthy**
- [ ] Significant weight change
- [ ] Recent change in strength or exercise tolerance

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- [ ] Headaches
- [ ] Vertigo/dizziness
- [ ] Head injury
- [ ] Changes in vision
- [ ] Eye pain

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- [ ] Dry **eyes**
- [ ] Changes in hearing
- [ ] Ringing in ears
- [ ] Bleeding from ears

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- [ ] **Nose** bleeds
- [ ] Sinus drainage
- [ ] Dental difficulties
- [ ] Bleeding gums
- [ ] Neck stiffness

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- [ ] **Neck** pain/tenderness
- [ ] Neck masses

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- [ ] **Breast** lumps
- [ ] Trouble breathing
- [ ] Nipple discharge
- [ ] Wheezing
- [ ] Breast tenderness/swelling
- [ ] Breast Skin changes
- [ ] Armpit lumps
- [ ] Cough

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- [ ] **Chest** pains
- [ ] Palpitations
- [ ] Fainting spells
- [ ] Can't sleep flat at night

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- [ ] **Abdominal** pains
- [ ] Changes in appetite
- [ ] Vomiting
- [ ] Painful swallowing

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- [ ] **Urinary** urgency
- [ ] Painful urination
- [ ] Changes in the nature of urine

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- [ ] Changes in **bowel** habits
- [ ] Blood in stool
- [ ] Constipation
- [ ] Diarrhea
- [ ] Excessive gas

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- [ ] Changes in **period** pattern
- [ ] Painful periods
- [ ] Heavy periods
- [ ] **Pelvic** pain
- [ ] Pain with sex
- [ ] Vaginal discharge
- [ ] **Vaginal** dryness
- [ ] Vaginal sores

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- [ ] Pain in **muscles** or joints
- [ ] Limitation of range of motion Numbness or tingling
- [ ] Tremor seizures
- [ ] Weakness

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- [ ] Trouble walking
- [ ] Changes in **thinking** pattern
- [ ] Depression
- [ ] Low Mood
- [ ] Blue
- [ ] Suicide ideas or plans

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Extra Notes, Questions: