General New Patient Information

Name: _____ **DOB**: ____/_____/_____ **Age**: _____ **Sex**: M / F

Cell: (_____)_____-_____ **Home**: (_____)_____-_____ **Email**:_____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Emergency Contact Information:

Name: _____ **Cell**: (_____)_____-_____ **Relation**:_____

Allergies: _____ **Primary Care:** _____

Are you on any medications or herbal supplements: Y / N _____

_____

Social History:

Do you smoke? Yes/ How much a day:_____ I use to/ Date Quit:_____ Never: _____

Do you drink alcohol? Yes/ How often: _____ I use to/ Date Quit: _____ Never: _____

Marriage Status? Single / Married / Widowed **Sexually Active**? Y / N **How did you hear about us**?_____

Female History:

Hysterectomy/Oophorectomy: Y / N **Date**:_____

BTL (Bilateral tubal Ligation): Y / N **Date**: _____

Gynecologist: _____ **Phone #** _____

Currently Pregnant? Y / N **Number of Pregnancies**? _____

Last Menstrual Cycle: ___/____/____

Last Pap Smear: ____/____/____ Normal or Abnormal

Last Mammogram: ____/____/____

Male History:

Vasectomy: Y / N Date: ____/_____/____

Erectile Disfunction: Y / N **How many years**: _____

Peyronie's Disease: Y / N **How many years:** _____

Lab Work Information:

Most recent labs: ____/____/____ **Was CBC checked**: Y / N

Facility Preference: _____

Do you have or had any of the following?

Circle the ones that apply to you

High Blood Pressure
Chronic Swollen Glands
Visual Impairment
Irregular Heartbeat
Thrombophlebitis
Heart Murmur
Thyroid Problems

Skin conditions
Asthma
Collagen Vascular Disease
Hernia
Kidney Disease
Weight Loss or Gain
Anemia

Transfusion
Breast Implants
Shortness of Breath
Bowel Obstruction
Diabetes
Alzheimer's
Psoriasis

Stomach Ulcers
Bladder Infection
Pacemaker
Eczema
Chest Pain
Mental Illness Seizures
Metal Implants