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Date: _____

First Name:	Middle Name:	Last Name:	Date of Birth:	Physician:
Date of last physical exam, with whom:				
Referring Physician:				

Medications: Please list all prescriptions including over-the-counter medications _____ None

Medication	Dose (# mg)	Instructions (ex: 1 daily)	How long have you been on this medication?

Write in the names of any diseases or conditions you have: _____ I do not have any medical problems

_____

_____

_____

Write in the names of any other provider(s) you obtain care from: _____ I do not have additional providers

_____

_____

_____

Serious illnesses which you have had: (ex: requiring hospitalization) _____ I have never been hospitalized

_____

_____

_____

_____

_____

Write in the names of any operations which you have had: _____ I have had no prior surgeries

Operation	Year	Operation	Year

Continued on other side…

Name any drugs to which you are allergic, list the symptoms caused: _____ No known medication allergy

Medication	Reaction

Have you ever had any of the following problems? If so, please provide approximate date (month/year):

Heart Attack:	Stroke:
Seizure:	Blood transfusion:
Cancer of, please specify:	
Sports injuries (including concussions):	

Do you know of any blood relative who has or had any of the following problems:

_____ I do not know my family history

If applicable, please list relationship:

Cancer: Breast	Epilepsy	Heart attack
Colon	Suicide	Stomach ulcers
Melanoma	Migraine	Kidney stones
Ovary	Asthma	Thyroid problems
Other	Eczema	Arthritis
Stroke	Bleeding problems	Leukemia
High blood pressure	Glaucoma	High cholesterol
Tuberculosis	Diabetes	Congenital heart disease
Colon polyps	Mental illness	Mitral valve prolapse
Colitis	Depression	Heart valve problems
Osteoporosis	Alcoholism	Aortic aneurysm
Other:		

Family History	If Living			If Deceased	
	Sex	Age	Medical Problems	Age of Death	Cause
Father					
Mother					
Brothers / Sisters					
Husband / Wife					
Sons / Daughters					

Print Name: _____

Date of Birth: _____

Date: _____

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You may complete this form online through your MyInterMed account at **www.intermed.com.**

This visit is scheduled to be for preventive health. In addition to your preventive care needs, please list below other topics or concerning symptoms you may be having and wish to discuss today:

(Please be aware that there may be additional charges to discuss non-preventive topics.)

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

Please list below any changes to your personal medical history that we may not be aware of:

1. _____
2. _____
3. _____

Please list below any changes to your life history (job, kids, relationships, etc.) or to your family's history since we last met:

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

Please list your medications below, including both prescription and over the counter medications:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Please check if you have any of the following potentially concerning symptoms.

Heart/Blood Vessels
Chest pain ☐
Shortness of breath ☐
Irregular, fast, or unusually strong heartbeats ☐
Leg swelling ☐
Leg pain/cramping with walking ☐
Fainting or dizziness ☐

Lungs
Wheezing ☐
Bothersome cough ☐
Bloody sputum ☐

Stomach/Bowels
Abdominal pain ☐
Blood in stool ☐
Excessive diarrhea ☐
Change in bowel movements ☐

Systemic Symptoms
Night sweats ☐
Unexplained weight loss/gain ☐
Fever or chills ☐
Excessive thirst or hunger ☐

Bladder/Sexual Organs
Blood in urine ☐
Painful urination ☐
Abnormal discharge ☐
Heavy or irregular periods ☐
Vaginal bleeding after menopause ☐
Vaginal bleeding after sex ☐
Sexual dysfunction ☐
Breast mass ☐

Skin
Black/bleeding/changing moles ☐

Mental Health
Bothersome stress ☐
Bothersome anxiety ☐
Thoughts of self-harm ☐

Brain/Nerves
Loss of coordination ☐
Weakness in limbs ☐
Slurred speech ☐

Vision
Partial or temporary loss of vision ☐

Provider Signature:_____ Patient Signature:_____

Print Name: _____

Date of Birth: _____

Date: _____

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Emotions:

Are you receiving mental health counseling? ☐ Yes ☐ No

Over the last two weeks, how often have you been bothered by or had little interest in doing things?
☐ Not at all ☐ More than half the days
☐ Several days ☐ Nearly every day

Over the last two weeks, how often have you been feeling down, depressed, or hopeless?
☐ Not at all ☐ More than half the days
☐ Several days ☐ Nearly every day

Social Determinants of Health:

Do you put off or neglect going to the doctor because of distance or transportation? ☐ True ☐ False

Within the past 12 months, have you worried that your food would run out before you got money to buy more?
☐ Often true ☐ Sometimes true ☐ Never true
☐ Don't know/decline

Within the past 12 months, has the food you bought not lasted and you didn't have money to get more?
☐ Often true ☐ Sometimes true ☐ Never true
☐ Don't know/decline

How often do you feel lonely?
☐ Often/Always ☐ Some of the time ☐ Occasionally
☐ Hardly Ever ☐ Never

Gender/Sexuality:

Do you think of yourself as: ☐ Straight or heterosexual
☐ Gay or lesbian ☐ Bisexual ☐ Pansexual ☐ I do not know
☐ Choose not to disclose ☐ Other_____

What is your current gender identity: ☐ Female ☐ Male
☐ Gender queer or not exclusively male or female
☐ Choose not to disclose

What are your pronouns: ☐ He/him ☐ She/her
☐ They/them ☐ Other_____

Are you sexually active? ☐ Yes ☐ No
Is/Are your sexual partner(s): ☐ Male ☐ Female ☐ Both
Have you had any new sexual partners since your last visit?
☐ Yes ☐ No
If yes, do you use condoms/protection?
☐ Always ☐ Sometimes ☐ Never
Contraception method(s): _____

Would you like to be screened for STDs? ☐ Yes ☐ No

Tobacco/Alcohol/Drug Use:

Smoking/Tobacco History:
☐ Current smoker ____ packs/day
☐ Former smoker and quit _____ years ago
☐ User of chewing tobacco/snuff/vaporized nicotine
☐ Never smoked or used tobacco

Marijuana use:

How many times in the past year have you used marijuana?
☐ Never ☐ Less than daily ☐ Daily

Drug use:

How many times in the past year have you used an illegal drug (not marijuana) or used a prescription medication for non-medical reasons?
☐ Never ☐ Once or twice ☐ Other _____

Alcohol use:

How often do you have a drink containing alcohol?
☐ Never ☐ Monthly or less ☐ Two to four times a month
☐ Two to three times a week ☐ Four or more times a week

On days that you drink, how many standard drinks containing alcohol do you consume?
☐ None, I do not drink ☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6
☐ 7 to 9 ☐ 10 or more

How often do you have six or more drinks on one occasion?
☐ Never ☐ Less than monthly ☐ Monthly
☐ Weekly ☐ Daily or almost daily

Lifestyle:

Do you exercise at least 150 minutes per week? ☐ Yes ☐ No
Number of days per week: _____
Do you eat a healthy diet? ☐ Yes ☐ No ☐ I Don't Know
Any concerns regarding weight or eating? ☐ Yes ☐ No
Have you had an eye exam in the past year? ☐ Yes ☐ No
Have you had a dental exam in the past year? ☐ Yes ☐ No
Are the guns in your home secured safely and separately from ammunition? ☐ Yes ☐ No ☐ N/A

Do you have a living will? ☐ Yes ☐ No

History/Risk of Falling:

Have you fallen in the last year? ☐ Yes ☐ No
If yes, did that fall result in injury? ☐ Yes ☐ No
Do you feel unsteady when standing or walking? ☐ Yes ☐ No
Are you worried about falling? ☐ Yes ☐ No

Domestic Abuse:

Is violence at home a concern for you? ☐ Yes ☐ No
Do you have past or current experience of being physically, emotionally, or sexually abused? ☐ Yes ☐ No

Provider Signature:_____ Patient Signature:_____

Print Name:_____

Date of Birth:_____

Date:_____

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OB/GYN and Sexual Health History Form

Gynecological/Sexual History:

First day of your last menstrual period (LMP): _____
How old were you when your period started? _____
Are your periods: ☐ Light ☐ Moderate ☐ Heavy
How long are your period cycles? _____
Do you have significant pain with your periods? ☐ Yes ☐ No
Are your periods regular in their timing? ☐ Yes ☐ No
How many days of menstrual flow? _____
Do you have bleeding between periods? ☐ Yes ☐ No

If applicable, age of menopause/year of last period? _____
Taken hormone medications since menopause? ☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No
Do you have pain with sexual activity? ☐ Yes ☐ No
Relationship status (*check all that apply*):
☐ Single ☐ Married ☐ Civil Union ☐ Domestic Partnership
☐ Multiple Partners ☐ Partnered, not cohabitating
☐ Divorced ☐ Widowed ☐ Committed Relationship ☐ Other

Current form of birth control: _____
Are you happy with it? ☐ Yes ☐ No

Past methods of birth control (*check all that apply*):
☐ Rhythm/Natural ☐ Family Planning ☐ Condoms
☐ Withdrawal ☐ Pill ☐ Patch ☐ NuvaRing ☐ Arm Implant ☐ Depo-Provera Injections ☐ Hormone IUD
☐ Copper IUD ☐ Essure Sterilization
☐ Tubal Ligation/removal ☐ Vasectomy ☐ Hysterectomy

Ever had an abnormal Pap or Colposcopy?
☐ Yes ☐ No

Have you had any treatments to your cervix?
☐ No ☐ Cryosurgery ☐ LEEP ☐ Conization

Have you ever had a sexually transmitted disease?
☐ No ☐ Chlamydia ☐ Gonorrhea ☐ Herpes
☐ Other: _____

Have you had the HPV vaccine (Gardasil) series?
☐ Yes ☐ No

Obstetrical History: (if applicable)

Total number of pregnancies: _____
Number of full-term pregnancies: _____
Number of premature pregnancies: _____
Number of multiple births: _____

Number of miscarriages: _____
Number of induced abortions: _____
Number of ectopic pregnancies: _____
Number of children living: _____

Date of Delivery	Preterm Labor? (Y/N)	Gestational Age (# of weeks)	Length of Labor (# of hours)	Birth Weight	Infant Sex	Type of Delivery (Vaginal/C-Section)	Pain medication (Y/N) If yes, what type?	Delivery Doctor and place of delivery	Complications of pregnancy or labor?