Girls to Women HEALTH AND WELLNESS

Young Men's HEALTH AND WELLNESS

MEDICAL HISTORY (NEW PATIENT)

PATIENT Legal Name: _____ **DOB**: ___/___/___ **Today's Date:** ___/___/___

Preferred First Name: _____ **Gender:** _____ **Pronouns:** _____

Please specify which type of visit is needed today***

PREVENTIVE and PROBLEM-FOCUSED services are considered ***separate*** procedures by your insurance company.

❒ **Annual PREVENTIVE Wellness Visit*** ** to address **GENERAL WELLNESS** topics**, including:**

- General health education
- General physical examination
- School / camp / college physical forms
- Review/order wellness screening labs, Pap test if applies
- Review / update immunizations
- Brief update of chronic, stable conditions
- Completion of annual forms for patients with disabilities

Most recent:

Annual Exam	Age/Date_____	Physician_____	❒ Normal ❒ Abnormal _____
Cholesterol	Age/Date_____	Physician_____	❒ Normal ❒ Abnormal _____
Anemia Screening	Age/Date_____	Physician_____	❒ Normal ❒ Abnormal _____
Other_____	Age/Date_____	Physician_____	❒ Normal ❒ Abnormal _____

AND / OR

❒ **PROBLEM-FOCUSED Visit (select all that apply)*****

- ○ Medication questions/refills (list)
- ○ Illness or physical symptoms
- ○ Sports injury
- ○ Social, emotional concerns
- ○ Nutrition / weight / body image
- ○ Social media / technology use
- ○ Menstrual / gynecology
- ○ Sexual health
- ○ Gender questions / concerns
- ○ Risk behaviors / safety
- ○ Other:

PLEASE EXPLAIN CONCERNS AND WHAT YOU HOPE TO GET FROM TODAY'S APPOINTMENT

***IMPORTANT NOTICE**

- If **BOTH PREVENTIVE AND PROBLEM-FOCUSED** services are provided, ***FEES FOR EACH SERVICE*** will be billed and/or another appointment may be needed.
- Due to the complex needs of our patients, some visits require **EXTENDED TIME; additional fees** may be billed in this case.

Kindly let us know **AT THE BEGINNING OF YOUR APPOINTMENT** if you have questions about these policies.

Your Name: _____ **Relationship to Patient:** ❒ Mother ❒ Father ❒ Self ❒ Other: _____

Signature: _____ **Date**: _____/_____/_____

Please provide AT THE BEGINNING OF APPOINTMENT any:

❒ Immunization Records ❒ Forms (e.g. camp, sports) that require medical provider signature ❒ Labs/Reports

Who referred you to Girls to Women / Young Men's Health and Wellness?

Referred by: _____ ❒ physician ❒ therapist ❒ Other: _____

Current Medications (prescription, over-the-counter, INCLUDING supplements) ❒ **None**

Name	Dose	Prescribing Physician	Requesting Refill Today?		Quantity Needed	
			❒ No	❒ Yes	❒ 30 day	❒ 90 day
			❒ No	❒ Yes	❒ 30 day	❒ 90 day
			❒ No	❒ Yes	❒ 30 day	❒ 90 day
			❒ No	❒ Yes	❒ 30 day	❒ 90 day
			❒ No	❒ Yes	❒ 30 day	❒ 90 day

Pregnancy/Early Development

Is patient adopted? ❒ No ❒ Yes (age of adoption/state or country of birth):

Prenatal / Birth History ❒ Normal ❒ Complications / Concerns:
❒ Pregnancy _____ weeks

Growth and Development

Physical (fine/gross motor) ❒ Normal ❒ Complications / Concerns:

Language / Communication ❒ Normal ❒ Complications / Concerns:

Cognitive / Intellectual ❒ Normal ❒ Complications / Concerns:

Social / Emotional / Personality ❒ Normal ❒ Complications / Concerns:

If applies, describe disabilities or concerns not identified above

Primary Care Provider (name/address/phone/fax if known) _____

Allergies **IF YES: Specify WHICH medications or foods AND DESCRIBE TYPE OF REACTION**

Medication Allergies	❒ None	
Food/Other Allergies	❒ None	

Surgeries	**Physician**	**Approximate Date or Age**

Hospitalizations: medical & psychiatric (include residential, PHP, IOP)	**Hospital or Physician**	**Approximate Date or Age, Duration**

Patient Social History

School: _____ Current Grade (e.g. 10th): _____ School Year (e.g 2018-2019) _____

Activities, Clubs, Hobbies, Interests:_____

Employment: _____

Family Members	
Mother	Occupation:
Father	Occupation:
Step-Mother	Occupation:
Step-Father	Occupation:
Other(s)	Occupation:
Sister(s)	Ages:
Brother(s)	Ages:

Parent(s)/Legal Guardian(s) are:
□ Married □ Widowed □ Single parent □ Separated
□ Divorced (□ Mom remarried □ Dad remarried)
□ Never married □ Other:

If divorced, separated, or never married, please describe
Custody arrangements:

Living arrangements:

Adverse Childhood Experiences (ACES) (explain if apply)

- ❒ physical abuse
- ❒ sexual abuse
- ❒ emotional abuse
- ❒ physical neglect
- ❒ emotional neglect
- ❒ parental separation or divorce
- ❒ intimate partner violence in household
- ❒ mother treated violently
- ❒ substance misuse within the household
- ❒ household mental illness
- ❒ incarcerated household member

Tuberculosis Questionnaire (from Texas Department of State Health Services)			
Tuberculosis TB can cause fever of long duration, unexplained weight loss, bad cough (lasting over 2 weeks), or coughing up blood.			
Please indicate if applies to patient:			
Been around someone with any of these symptoms or problems?	❒ No	❒ Yes	❒ Don't Know
Had any of these symptoms or problems?	❒ No	❒ Yes	❒ Don't Know
Been around anyone sick with known tuberculosis?	❒ No	❒ Yes	❒ Don't Know
Born in Mexico or other country in Latin America, Caribbean, Africa, Eastern Europe or Asia?	❒ No	❒ Yes	❒ Don't Know
Traveled in the past year to Mexico or any other country in Latin America, Caribbean, Africa, Eastern Europe or Asia for longer than 3 weeks? **If yes, which country/countries?**	❒ No	❒ Yes	❒ Don't Know
To your knowledge, spent time (longer than 3 weeks) with anyone who is/has been an intravenous (IV) drug user, HIV-infected, in jail or prison or recently came to the United States from another country?	❒ No	❒ Yes	❒ Don't Know
Been tested for TB in the past?	❒ No	❒ Yes _____ date(s)	
Ever had a positive TB skin test?	❒ No	❒ Yes _____ date(s)	
Ever been treated for TB?	❒ No	❒ Yes _____ date(s)	

MEDICAL HISTORY

	Age	If Applies
Allergy/Asthma/Immunology		Allergist:
❒ seasonal allergies		
❒ asthma		
❒ cough with exercise		Pulmonologist:
❒ chronic cough (>3 weeks)		
❒ immune deficiency		
❒ other:		
Cardiovascular		Cardiologist:
❒ innocent heart murmur		
❒ hole in heart (ASD or VSD)		
❒ abnormal heart valve(s)		
❒ high blood pressure		
❒ high cholesterol/triglycerides		
❒ chest pain with exercise		
❒ passing out during/after exercise		
❒ POTS		
Hematology		Hematologist:
❒ anemia		
❒ thalassemia		
❒ bleeding disorder		
❒ blood clot / clotting disorder		
❒ abnormal weight loss		
❒ severe drenching night sweats		
❒ cancer (specify type):		
❒ other:		
Gastroenterology		Gastroenterologist:
❒ GERD (reflux)		
❒ irritable bowel syndrome		
❒ chronic constipation		
❒ Crohn's or ulcerative colitis		
❒ celiac disease		
❒ gall bladder / liver disease		
❒ other:		
Dermatology		Dermatologist:
❒ acne		
❒ eczema		
❒ poor wound healing		
❒ recurrent hives		
❒ other:		
Endocrine		Endocrinologist:
❒ thyroid disorder		
❒ diabetes (type 1)		
❒ diabetes (type 2)		
❒ PCOS diagnosis		
❒ other:		
Nutritional		Dietitian:
❒ abnormal weight loss		
❒ vegan or vegetarian		
Infectious Disease		Infectious Diseases:
❒ chicken pox		
❒ mononucleosis		
❒ recurrent severe infections		
❒ MRSA (staph)		
❒ tuberculosis		

	Age	If Applies
Vision/Dental/Hearing		Ophthalmologist:
❒ wears glasses or contacts		
❒ vision impairment >glasses/contacts		Audiologist:
❒ hearing loss		
❒ dental problems (significant)		Dentist:
❒ other:		
Orthopedic / Rheumatologic		Orthopedist:
❒ scoliosis		
❒ arthritis		
❒ joint hypermobility		Rheumatologist:
❒ joint dislocation(s) (frequent)		
❒ EDS Ehlers Danlos Syndrome		Physical Therapist:
❒ broken bones (specify):		
Neurology		Neurologist:
❒ migraines ***with*** aura (visual changes before headache)		
❒ migraines ***without*** aura		
❒ sleep apnea		Sleep specialist:
❒ tics		
❒ seizures		
❒ fainting		
❒ concussion(s)		
❒ other:		
Gynecology/Urology		Urologist:
❒ UTI's (recurrent)		
❒ kidney disease		Nephrologist:
❒ testicular torsion or loss		
❒ ovarian cyst(s)		
❒ excessive menstrual bleeding		Gynecologist:
❒ STI/STD's		
❒ pregnancy		
❒ other:		
Neurodevelopmental		Genetics/Dev'p Peds:
❒ genetic disorder		
❒ developmental delay		
❒ speech or language disorder		Speech therapist:
❒ learning disability		
❒ autism spectrum disorder		OT:
❒ Asperger's		
❒ ADD/ADHD		Testing Psychologist:
❒ other:		
Mental Health		Psychologist/Therapist
❒ depression		
❒ anxiety		
❒ panic attacks		Psychiatrist:
❒ obsessive compulsive disorder		
❒ eating disorder		Dietitian:
❒ bipolar disorder		
❒ schizophrenia		
❒ drug abuse		
❒ gender dysphoria		
❒ self-harm behavior		Treatment Centers:
❒ suicide attempt		
❒ other:		

FAMILY MEDICAL HISTORY

❒ adopted, no information about birth family

	Mother	Father	Siblings	Grandparents	Other
Asthma					
Bleeding disorder					
Blood disorders (e.g. thalassemia or sickle cell anemia)					
Clotting disorder					
Cancer—breast					
Cancer—endometrial/uterine					
Cancer—ovarian					
Cancer—testicular					
Crohn's disease					
Deep venous thrombosis (DVT) or pulmonary embolism (PE) (include age)					
Diabetes (type 1)					
Diabetes (type 2)					
Endometriosis					
Enlarged heart (dilated cardiomyopathy or hypertrophic myopathy)					
Heart attack (include age)					
Heart rhythm abnormality (e.g. Long QT syndrome or other ion channelopathy (Brugada syndrome, etc), Marfan's syndrome)					
High blood pressure					
High cholesterol					
Kidney disease					
Migraine headaches					
Obesity					
PCOS (polycystic ovarian syndrome)					
Rheumatoid arthritis					
Other autoimmune disorders:					
Stroke (include age)					
Sudden cardiac death before age 50					
Thyroid disease					
Ulcerative colitis					
Other (please specify):					

FAMILY MENTAL HEALTH HISTORY

❒ adopted, no information about birth family

	Mother	Father	Siblings	Grandparents	Other
ADD/ADHD					
Anxiety					
Bipolar Disorder					
Eating disorder					
Depression					
Learning disability					
OCD					
Schizophrenia					
Substance abuse—alcohol					
Substance abuse—marijuana or other drugs					
Other addictions					
Suicide					
Other (please specify):					