The Whole Woman, PLLC

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Male New Patient Information Form

Name: _____ Age: _____ DOB: _____ DOS:_____

Referring Physician:_____ Primary care physician:_____

Trying to conceive? No ☐ Yes ☐ If so how long?_____ (years and months)
Date last PSA:_____ Result:_____
Date last colonoscopy:_____ Result:_____ Recommended f/u:_____ (years)
Date last bone density:_____ Result:_____

Social History:

Alcohol use: yes no type:_____ #/day:_____ #/week:_____
Caffeine use: yes no type:_____ #/day:_____ #/week:_____
Tobacco use: yes no type:_____ #/day:_____
Recreational drug use ever: yes no type:_____
Recreational drug use current: yes no type:_____ how often:_____
Regular excersize: yes no type:_____ days/week:_____
Occupation:_____

Marital status: M S W D (circle all that apply) Years together:_____
Partner's name:_____ Age:_____ Occupation:_____

General Symptoms: (circle if current problem)

Weight gain >10 lbs	Vision problems	Fatigue	Depression
Weight loss > 10 lbs	Diarrhea	Clumsiness	Food cravings
Nausea/Vomiting	Allergies	Constipation	Food intolerance
Bowel cramping	Acid reflux	Low sugar	Dry eyes
Memory problems	Brittle nails	Dry hair	Hair loss
Numbness hands/feet	Headache	Joint pain	Muscle pain/ache
Heat intolerance	Mouth sores	Tongue sores	Dry skin
Cold intolerance	Easy bruising	Insomnia	Cough/breathing problems
Blood in stool	Dizziness	Fainting	Easy bleeding
Intestinal cramping	Palpitations	Excessive thirst	Chest pain

Other:_____

Name: DOB: DOS:

Medical History:

Eyes:_____ Nose:_____
Ears:_____ Thyroid:_____
Neurolgic:_____ Heart:_____
Lungs:_____ Skin:_____
Gastrointestinal:_____ Blood:_____
Liver:_____ Kidney:_____
Bladder:_____ Mental:_____
Autoimmune:_____ Infections:_____
Cancer:_____ Diabetes (type and years):_____

Other:_____

Surgical History (include surgery, date, and where performed): _____

_____

_____

Family History (include chronic illness, cancer, genetic disorder, bleeding/clotting disorder, pregnancy/gyn problems, etc.):

Maternal grandmo.: _____ Maternal grandfa.:_____

Paternal grandmo.:_____ Paternal grandfa.:_____

Mother:_____ Father:_____

Sisters:_____

Brothers:_____

Children:_____

Aunts:_____

Uncles:_____

Ancestral Background: (certain illness and genetic disorders are more common in particular ancestral backgrounds):

☐ African ☐ French Canadian ☐ Latin American ☐ Ashkenazi Jewish
☐ Mediterranean ☐ Native American ☐ Caribbean ☐ Sephardic Jewish
☐ Asian ☐ Indian ☐ Other:_____

Do you use natural family planning: yes no type:_____

Name: DOB: DOS:

Current Medications (include prescription, over-the-counter, vitamins, and supplements):

Medication	Dose/Frequency	Reason for using

Allergies (include medication and reaction):

Name: DOB: DOS:

CC:_____

HPI:_____

Physical Exam:

BP:_____ P:_____ Ht:_____ Wt:_____ BMI:_____ T:_____

General: ☐WD ☐ WN ☐ NAD ☐ _____ groomed

Skin: ☐warm, dry, Ølesion ☐excessively dry ☐hirsutism _____ ☐cystic acne

_____

HEENT: ☐normocephalic ☐atraumatic ☐_____ ☐LAN_____ ☐Øthyromegally

☐_____ goiter ☐ _____ nodule ☐ _____ conjunctival pallor ☐ _____ dentition

☐_____ scleral icterus ☐ _____ oral ulcers _____

CV: ☐RRR ☐Ø M|R|G _____

Resp: ☐ctab ☐ØW|R|C ☐unlabored_____

Abdomen: ☐soft ☐NT ☐ND ☐NABS ☐Ømass ☐obese_____

Neuro: ☐nml tandem gait ☐CNII-XII intact grossly ☐DTRs _____ ☐strength_____ _____

Psych: ☐a+ox3 ☐mood+affect approp _____SI ____HI ☐ Ødel/hal/par _____eye contact J/I _____

speech- ☐ spont ☐non-pres ☐ intact ☐ ØFOI ☐Øpersev _____psychomotor act _____

Back: ☐ØCVA TTP ☐Scoliosis_____ ☐lordosis ☐trigger point_____

Extremities: ☐edema_____ ☐nail ridging ☐nail pitting ☐nail fungus ☐arthritic changes

Rectal: ☐nml tone ☐Ømass ☐_____ stool ☐hemorrhoids_____ FOB: ☐pos ☐neg

UA: gluc_____ bill_____ ket_____ sp gr_____ bld_____ pH_____ prot_____ urobll_____ nlt_____ leuk_____

☐urine ex ☐urine gc/cl

Name: DOB: DOS:

Imp/Plan:

Follow-up:

Schedule:

Referral:

Patient Education: