**Rochester Center for Sexual Wellness**

Sexual Medicine Intake Form

Welcome! Please take the time to fill out this form as accurately as possible so we can most appropriately address your health needs. Please try to fill out as much as you can in advance of your appointment. **The more information you can provide here, the more time we will have to spend on the issues you really want to discuss.** If you do not feel comfortable answering these questions in this way, we can discuss these issues during your appointment. The confidentiality of your health information is protected in accordance with federal and state protections for the privacy of health information under the Health Insurance Portability and Accountability Act (HIPAA). While we recognize there are many sexes/genders, many insurance companies and legal entities do not. Please understand that the legal name and sex listed on your insurance must be used on documents pertaining to insurance and billing. If your preferred name and pronouns are different from these, please let us know.

Please print all responses.

|  |  |
| --- | --- |
| Preferred name: | Legal Name:  |
| Address: |
| Home phone: OK to leave a message? Y N | Work phone: OK to leave a message? Y N |
| Mobile Phone: OK to leave a message? Y N | Email: OK to contact you by email? Y N |
| Date of Birth:  | Legal Sex & Gender Identity: |
| Insurance Provider:  | Insurance ID#: |
| Insurance Subscriber: | Language (most fluent):Do you need an interpreter? Y N |
| Highest level of education:  | Occupation: |
| Relationship/Marital Status: | Name of partner(s)/spouse (if applicable) |
| Who lives at home?  | Children, ages: |

**How would you rate your health? (circle one): Excellent / Good / Fair / Poor**

**Please list healthcare providers (& their specialty) you see regularly:**

**Name Specialty Last Visit Phone/Address**

**ALLERGIES or intolerance to medications?** □ **NONE** (If yes, to what & what reaction?)

**MEDICATIONS:** Please list (or show us your own printed record) **all** prescriptions and non-prescription medications. **This includes vitamins, herbs, supplements, home remedies, birth control pills, inhalers, over the counter pain pills (Advil, Aleve, Tylenol, etc).**

❑Check box if you do not take any prescription or over the counter medications.

❑Check box if you brought a list of your medications (you don’t need to fill them in below)

|  |  |  |
| --- | --- | --- |
| Medication  | Dose (e.g. mg/pill)  | How many times per day?  |
|  |   |   |
|  |   |   |
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|  |
| --- |
| **Past medical history** |
| Do you now or have you ever had: |  |  |
|  |  |  |
| ❑ Diabetes | ❑ Neurological disease(eg MS) | ❑ Liver disease |
| ❑ High blood pressure | ❑ Stroke | ❑ Tuberculosis |
| ❑ High cholesterol | ❑ Peripheral neuropathy | ❑ HIV/AIDS |
| ❑ Hypo or hyperthyroidism | ❑ Epilepsy (seizures) | ❑ Arthritis |
| ❑ Heart disease | ❑ Traumatic Brain Injury | ❑ Depression |
| ❑ Cancer (type)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ❑ Kidney disease❑ Incontinence | ❑ Anxiety |
| ❑ Psoriasis or other skin condition(type) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ❑ GI disease (colitis, IBD, IBS) (type)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ❑ Other mental health issues \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ❑ Asthma or COPD | ❑ Stomach or peptic ulcer |  |
| **Other medical problems:** |  |  |
| **Major childhood illnesses:**  |  |  |
| **Past surgeries:** |  |  |
|  |  |  |

Are you up to date on preventive health such as immunizations, colon cancer screening, breast cancer screening, cervical cancer screenings? YES/NO Do you see a primary care provider regularly? YES/NO

What is your Gender Identity? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you wish to discuss this?

Do you think of your sexual orientation as:

❑ Lesbian, gay, or homosexual ❑ Straight or heterosexual ❑ Bisexual ❑ Something else ❑ Don’t know

When was the last time you were tested for HIV?

Please check any of the following infections that you have had:

❑Syphilis ❑Herpes (HSV) ❑Yeast Infections ❑ Bacterial Vaginosis ❑Gonorrhea ❑Trichomonas ❑Chlamydia ❑Pelvic Inflammatory Disease ❑Genital Warts ❑ HPV ❑ Other

**Gynecologic History**  (*If not applicable due to biological sex please skip to next section)*

Age of First Period: \_\_\_\_ Date of last period: \_\_\_/\_\_\_/\_\_\_ (if postmenopausal, please skip to the next section)

Are periods regular? \_\_\_\_ Length of cycle in days: \_\_\_\_ Significant pain with periods? \_\_\_\_\_

Other Bleeding: ❑NO ❑YES, between periods ❑YES, after penetrative sexual activity

Do you experience any of the following symptoms with your period?

❑Headaches ❑Weight Gain ❑Swelling ❑Cramps ❑Anxiety ❑Depression ❑Other:

Are you currently using birth control? ❑YES ❑NO If YES: Which type are you using:

❑Pills ❑IUD ❑Condoms ❑ Foam ❑Foam & Condoms ❑Patch ❑Diaphragm ❑Ring ❑Depo ❑Tubal Ligation ❑ Vasectomy ❑ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever taken hormonal birth control (pills/patch/ring)? ❑YES, for how many years \_\_\_\_\_\_\_\_\_\_ ❑NO

Are you currently pregnant or planning to become pregnant? ❑YES ❑NO

Date of Last Pap: \_\_\_/\_\_\_/\_\_\_

Have you ever had:

❑ An abnormal Pap?

❑ Fibroids?

❑ Have you had a hysterectomy? If YES: Why was it performed?

 Were your ovaries removed? ❑YES, BOTH ❑YES, ONE ❑NO

How many times have you been pregnant? \_\_\_\_\_ How many miscarriages or terminations? \_\_\_\_\_

How many vaginal deliveries have you had? \_\_\_\_\_ How many caesarean sections? \_\_\_\_\_

Have you had any ectopic pregnancies? ❑YES ❑NO Have you had gestational diabetes? ❑YES ❑NO

Do you have a history of treatment for infertility? ❑YES ❑NO

*If you have not begun menopause, please skip to the next section:*

Age at menopause: \_\_\_

Have you ever taken estrogen replacement? ❑YES ❑NO Have you ever taken progesterone? ❑YES ❑NO

Please check any of the following symptoms of menopause you are having:

❑ Hot Flashes ❑ Fatigue ❑ Depression ❑ Insomnia ❑ Vaginal Burning/Itching ❑ Pain during Vaginal Penetration ❑ Anxiety ❑ Irregular Bleeding ❑Vaginal Dryness ❑ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Urologic History** (*If not applicable due to biological sex please skip to next section)*

Have you ever been diagnosed with a prostate problem? ❑YES ❑NO

Have you ever had any of the following? ❑Prostate Surgery ❑ Penile Prosthesis ❑ Prostate Biopsy ❑ Scrotal Area Surgery ❑ Testicle Removal ❑Varicocele Surgery ❑ Vasectomy

Have you ever used erectile enhancement prescription medications? ❑YES ❑NO

Have you ever used any supplements or non-prescribed medications for sexual enhancement? ❑YES ❑NO

**Hormones for Gender/Sex Alignment** (*If not applicable, please skip to the next section.)*

Are you currently taking hormones for gender alignment purposes? ❑YES ❑NO

If YES: How long have you been taking them? \_\_\_\_\_\_\_\_\_\_\_\_\_

What hormones are you taking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever used gender alignment hormones in the past? ❑YES ❑NO

What types, if any, of gender alignment surgeries or procedures have you had?

**Lifestyle & Health Habits**

Do you follow a special diet? ❑YES ❑NO If YES: ❑Vegetarian ❑Vegan ❑Low Fat ❑Low Carb ❑High Fiber ❑Calorie Restriction ❑Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you exercise at a moderate or vigorous level for 30 minutes or more? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of exercise(s) and/or sports do you engage in?

Are you a regular bike rider/cyclist? ❑YES ❑NO How many miles per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a horse rider? ❑YES ❑NO How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a typical day, how many cups of caffeine beverages (coffee, tea, soda, energy drinks, etc) do you have? \_\_\_\_

**Alcohol:**

How many drinks containing alcohol do you have, on average, per week? \_\_\_\_\_ What kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been concerned about your drinking? ❑YES ❑NO ❑Not Sure

Has anyone, including a family member, friend, or healthcare worker been concerned about your drinking or suggest you cut down? ❑YES ❑NO ❑I’m not sure

**Tobacco:**

How many cigarettes do you smoke per day? \_\_\_\_\_ How many years have you been smoking? \_\_\_\_

Have you ever tried to quit smoking? ❑YES ❑NO ❑NA

If you are a former smoker, how long ago did you quit? \_\_\_\_\_\_

Do you use tobacco in any other form?

**Recreational Drugs:**

Please check any of the substances listed below that you have used, even if it was only once:

❑ Marijuana ❑Cocaine ❑Crystal Meth ❑Heroin ❑Other Opiates (oxycontin, vicodin, percodan, etc)

❑Ecstasy/Mushrooms/LSD ❑ Stimulants (Amphetamine, Ritalin, Adderall, etc)

❑ Other Substance(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_