New Patient Health History (MH)

Name: _____ DOB: _____ Pharmacy: _____ Date: _____

What is the reason for your appointment today? _____

Primary care provider: _____ OB/GYN provider: _____

Did someone refer you to our clinic? □ NO □ YES Name of referring provider/ person: _____

Would you like us to communicate with your referring provider? □ NO □ YES If yes, have you completed the necessary forms? □ NO □ YES

Relationship status: □ Single □ Engaged □ Married □ Separated □ Divorced □ Widowed □ Remarried □ Cohabitating

Children (name and ages): _____ Primary language: _____ Tribe/Nation/Ethnicity: _____

Currently living with: □ Children □ Spouse/significant other □ Extended family □ Other: _____

Sexual Orientation: □ Heterosexual □ Homosexual □ Bisexual □ Other _____ □ I prefer not to answer

Gender Orientation: □ Female □ Male □ Transgendered □ Other _____ □ I prefer not to answer Preferred Pronouns: _____

Sexually active: □ NO □ YES Birth control method: _____ Sexual health concerns: _____

History of STD? □ NO □ YES How old were you when your period started? _____ Date of last menstrual period: _____

Are you postmenopausal? □ NO □ YES If yes, what year did you become menopausal? _____

Attempting pregnancy? □ NO □ YES Infertility concerns □ NO □ YES

Obstetrical History (if applicable)

Date of Delivery	Sex of child	Weeks Gestation	Vaginal	C-Section	Miscarriage	Abortion	Stillbirth

Are you currently pregnant? □ NO □ YES If yes, how many weeks/due date? _____ Are you currently breastfeeding? □ NO □ YES

Social History

Growing up I lived with (check all that apply): □ Mother □ Father □ Brother □ Sister □ Extended family □ Foster home □ Stepparent(s) □ Step-siblings □ Other: _____

Education history: □ current student (grade/major) _____ □ did not complete high school/last grade completed _____

□ GED/diploma completion □ some college/vocational school □ College graduate (degree) _____

Work status: □ Unemployed □ Disabled _____ □ Stay at home mom □ Employed/occupation:_____

□ Student/school: _____ Year graduated/major: _____

Sleep: Average __ hours per night. □ Difficulty falling asleep □ Difficulty staying asleep □ Difficulty getting out of bed □ Not feeling rested □ Shift work

Dietary preferences: □ Vegetarian □ Vegan □ Diabetic □ Keto □ Gluten-free □ Dairy-free □ Other: _____

Current or history of: □ Binge/overeating □ Food restriction □ Purposeful vomiting □ over-exercising

Exercise: □ No □ Yes If yes, what is your exercise routine? _____

Things you like to do for self-care: □ Reading □ Writing □ Meditation □ Time with friends/family □ Yoga

□ Other: _____

Mental/Physical Health History

Have you ever received mental healthcare treatment before (either inpatient or outpatient)? □ No □ Yes, please list below:

Provider/Facility	Age at the time of treatment	Reason for seeking help

Have you ever taken psychiatric medications (antidepressants, benzodiazepines, stimulants, mood stabilizers)? □ No □ Yes, please list below:

Name	Age or year taken	Reason for taking	Reason for stopping	

Current medications and dose (please include any and all over-the-counter supplements/vitamins):

Medication/Supplement	Current dosage	How long have you been taking this?	Prescribing provider?	Condition being treated?

Substance Use History

Type (circle please)	Self or Family Member (who?)	Current Use?	Amount per Day/Week/Month	Age/Year when stopped use?	Inpatient or Outpatient treatment/counseling?
Alcohol					
Tobacco (smoked, vaped, chewed)					
Marijuana/Cannabis					
Stimulants (cocaine, crack, speed, amphetamines)					
Opioids (heroin, narcotics, methadone)					
Methamphetamine, molly, ecstasy					
Hallucinogens (LSD, PCP, mushrooms)					
Sedatives, Hypnotics, Benzodiazepines					
Inhalants (gas, paint, glue)					
Designer Drugs/herbals (Kratom, Kava, CBD, cannabinoids- K2, spice)					

Mental/Physical Health History

Please indicate if any of the following have been present in yourself or your relatives:

	Self	Children	Brother(s)	Sister(s)	Father	Mother	Grandparent(s)	Aunt/Uncle
Adoption							□ Maternal □ Paternal	□ Maternal □ Paternal
Anxiety							□ Maternal □ Paternal	□ Maternal □ Paternal

Autism							□ Maternal □ Paternal	□ Maternal □ Paternal
ADHD							□ Maternal □ Paternal	□ Maternal □ Paternal
Bipolar illness							□ Maternal □ Paternal	□ Maternal □ Paternal
Depression							□ Maternal □ Paternal	□ Maternal □ Paternal
Dementia							□ Maternal □ Paternal	□ Maternal □ Paternal
Eating Disorder							□ Maternal □ Paternal	□ Maternal □ Paternal
Psychiatric hospitalization							□ Maternal □ Paternal	□ Maternal □ Paternal
PTSD							□ Maternal □ Paternal	□ Maternal □ Paternal
Psychosis							□ Maternal □ Paternal	□ Maternal □ Paternal
Panic							□ Maternal □ Paternal	□ Maternal □ Paternal
Schizophrenia							□ Maternal □ Paternal	□ Maternal □ Paternal
Suicide							□ Maternal □ Paternal	□ Maternal □ Paternal
Verbal abuse							□ Maternal □ Paternal	□ Maternal □ Paternal
Emotional abuse							□ Maternal □ Paternal	□ Maternal □ Paternal
Physical abuse							□ Maternal □ Paternal	□ Maternal □ Paternal
Sexual abuse							□ Maternal □ Paternal	□ Maternal □ Paternal
Witnessed Domestic violence							□ Maternal □ Paternal	□ Maternal □ Paternal
Narcissistic traits							□ Maternal □ Paternal	□ Maternal □ Paternal
Personality disorder							□ Maternal □ Paternal	□ Maternal □ Paternal
Learning Disability							□ Maternal □ Paternal	□ Maternal □ Paternal
Cancer (type?)							□ Maternal □ Paternal	□ Maternal □ Paternal
Heart Disease							□ Maternal □ Paternal	□ Maternal □ Paternal
High blood pressure							□ Maternal □ Paternal	□ Maternal □ Paternal
High cholesterol							□ Maternal □ Paternal	□ Maternal □ Paternal
Kidney Disease							□ Maternal □ Paternal	□ Maternal □ Paternal
Liver Disease							□ Maternal □ Paternal	□ Maternal □ Paternal
Thyroid disease							□ Maternal □ Paternal	□ Maternal □ Paternal
Mental Disability							□ Maternal □ Paternal	□ Maternal □ Paternal
Migraine							□ Maternal □ Paternal	□ Maternal □ Paternal
Diabetes							□ Maternal □ Paternal	□ Maternal □ Paternal
Thyroid Disease							□ Maternal □ Paternal	□ Maternal □ Paternal
Other _____							□ Maternal □ Paternal	□ Maternal □ Paternal

Is there anything else you would like us to know?

_____

_____

_____

Thank you for your time in completing this paperwork.

MEDICAL RECORDS REQUEST FOR CONTINUATION OF PATIENT CARE

Patient Name: _____ Date of Birth: ____/____/_____

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

Receiving Records from:

Provider or Clinic Name: _____

Phone Number: _____

Fax Number: _____

Please forward the above patient's medical records to the following provider:

Provider Name: Melissa Hoffman, DNP, APRN_____

Clinic Name: Lawrence Ob-Gyn Specialists

Phone Number: 785-505-4950 option 2

Fax Number: 785-505-5240

Information to be disclosed:

- ☐ Emergency Room Record
- ☐ History & Physical
- ☐ Complete Medical Record (all pages)
- ☐ Laboratory Reports
- ☐ Consultation
- ☐ Obstetrics Care
- ☐ Radiology Reports
- ☐ Operation/Procedure
- ☐ Gynecology Care
- ☐ Pathology Reports
- Final ☐ Case Summary
- ☐ Physician Office Records (specify clinic(s)):_____
- ☐ Test Result(s) of:_____
- ☐ Other:_____

Covering the period of healthcare from: Date(s):_____ to _____ **OR** ☐ All Dates (transfer of care)

SIGNATURE:_____

(PATIENT Signature) (DATE)