Name (to be called) _____Name Listed with Insurance (if different):_____
Pronoun_____ Birthdate _____

Magnolia New Patient Medical Intake Form

This form helps us learn about your medical history. Please complete it to the best of your ability. Not every question is relevant to everyone. If you feel uncomfortable answering a question, leave it blank.

Do you need help with this form? ☐ Yes ☐ No
If you answered yes, please stop filling out the form and speak with a Front Desk staff member.

Person filling out this form (if not the client): _____
Name Relationship to Patient

Medical History

What medical conditions do you have? ☐ None (Skip this section)

- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ High Blood Pressure/Hypertension
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ History of Stroke
- ☐ History of Heart Attack
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Liver Disease_____
- ☐ Pancreatitis
- ☐ Kidney Disease_____
- ☐ Breast Disease_____
- ☐ Thyroid Disease_____
- ☐ Migraines
- ☐ Blood clots
- ☐ Chronic Pain _____
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Autoimmune Disease_____
- ☐ Epilepsy
- ☐ Traumatic Brain Injury
- ☐ Pituitary Adenoma
- ☐ Alzheimer's or Dementia
- ☐ Hearing Impairment
- ☐ Blindness
- ☐ Intersex Condition_____
- ☐ Sleep Apnea
- ☐ Allergies
- ☐ Asthma
- ☐ COPD or Emphysema
- ☐ Tuberculosis (TB)
- ☐ Cancer _____
- ☐ HIV or AIDS
- ☐ HSV (Herpes)
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Polycystic Ovarian Syndrome (PCOS)
- ☐ Incontinence
- ☐ Hemorrhoids
- ☐ Irritable Bowel Syndrome
- ☐ Other medical conditions not listed:

_____

Mental Health History

What mental health conditions do you have? ☐ None (Skip this section)

- ☐ Depression
- ☐ Anxiety
- ☐ PTSD
- ☐ Bipolar I
- ☐ Bipolar II
- ☐ Obsessive Compulsive Disorder
- ☐ Schizoaffective Disorder
- ☐ ADD/ADHD
- ☐ Autism Spectrum Disorder
- ☐ Eating Disorder
- ☐ Substance Use Disorder (sober or currently using)
- ☐ Alcoholism (sober or currently using)
- ☐ Other mental health conditions not listed:

_____

Allergies

What are your allergies and what is your reaction? ☐ None (Skip this section)

Medications _____ ☐ None
Foods _____ ☐ None
Animals/Insects _____ ☐ None

If your allergic reaction is anaphylaxis, do you have an epi-pen? ☐ Yes ☐ No

Date: _____

Name (to be called) _____Name Listed with Insurance (if different):_____
Pronoun_____ Birthdate _____

Medications

What medicines (prescription and over-the-counter), vitamins, supplements and herbs do you take (regularly and as needed)? ☐ None (Skip this section)

Name	*Dose*	*How often?*	*What is it for?*

Do you often have trouble remembering to take medicines? ☐ Yes ☐ No

Family Medical History

To your knowledge, have any of your blood relatives had any of the following? If so, please indicate who of your blood relatives has the condition. ☐ None ☐ Unknown (Skip this section)

☐ Diabetes	_____	☐ Sickle Cell Anemia	_____	☐ Blood Clots	_____
☐ High Cholesterol	_____	☐ Osteoporosis	_____	☐ Breast Cancer	_____
☐ High Blood Pressure	_____	☐ Parkinson's Disease	_____	☐ Cervical Cancer	_____
☐ Heart Attack	_____	☐ Alzheimer's Disease	_____	☐ Ovarian Cancer	_____
☐ Stroke	_____	☐ Mental health issues	_____	☐ Colon Cancer	_____
☐ Heart Surgery	_____	☐ Alcoholism	_____	☐ Prostate Cancer	_____
☐ Thalassemia	_____	☐ Drug User	_____	☐ Thyroid Condition	_____

☐ Not Listed:_____

Past Surgical History

What surgeries have you had in the past and in what year? ☐ None (Skip this section)

☐ Appendix removal	_____	☐ Breast Reduction	_____	☐ Breast Implants	_____
☐ Tonsils removal	_____	☐ Bilateral Mastectomy	_____	☐ Orchiectomy	_____
☐ Hernia repair	_____	☐ Hysterectomy	_____	☐ Vulvoplasty	_____
☐ Gall bladder removal	_____	☐ Oopherectomy	_____	☐ Vaginoplasty	_____
☐ Orthopedic	_____	☐ Metoidioplasty	_____	☐ Tracheal Shave	_____
☐ Breast lumpectomy	_____	☐ Phalloplasty	_____	☐ Facial Surgery	_____
☐ Unilateral mastectomy	_____	☐ Scrotoplasty	_____	☐ Body Contouring	_____

☐ Not Listed:_____

Have you ever injected or pumped silicone, oils, or other substances for the purpose of body shaping? ☐ Yes ☐ No

Name (to be called) _____Name Listed with Insurance (if different):_____
Pronoun_____ Birthdate _____

Hospitalizations

Other than for surgery or childbirth, have you ever been hospitalized overnight for a medical or mental health issue? ☐ Yes ☐ No

Date	Doctor	Hospital	*What* was *it for?*

Vaccinations

Did you receive childhood vaccinations?	☐ No	☐ I'm not sure	☐ Yes
Have you been vaccinated for:		**Approximate Date**	
HPV (Gardasil)	☐ No	_____	☐ Yes
Tetanus / TdaP	☐ No	_____	☐ Yes
Hepatitis A	☐ No	_____	☐ Yes
Hepatitis B	☐ No	_____	☐ Yes
Influenza (Flu)	☐ No	_____	☐ Yes
Pneumonia (Pneumovax)	☐ No	_____	☐ Yes
Chicken pox (Varavax)	☐ No	_____	☐ Yes
Shingles (Zostavax)	☐ No	_____	☐ Yes
Meningitis	☐ No	_____	☐ Yes

When was the last time you had a test for tuberculosis (TB)? _____
What was the result?_____

Have you ever had a positive test for TB?	☐ Yes	☐ Unsure	☐ No
If yes, did you complete ≥ 6 months of preventative treatment?	☐ No	☐ Unsure	☐ Yes

Are you experiencing any of the following symptoms?

☐ cough > 3 weeks ☐ unexplained weight loss
☐ coughing up blood ☐ drenching night sweats

Have you had known contact with someone known to have TB disease of the lung?	☐ Yes	☐ No
Were you born in Asia, Africa, Latin America or Eastern Europe?	☐ Yes	☐ No
Have you spent more than 2 weeks in Asia, Africa, Latin America, or Eastern Europe in the past 2 years?	☐ Yes	☐ No
Have you been in prison/jail in the past 5 years?	☐ Yes	☐ No
Do you work with people who use drugs, are migrant workers, or are experiencing homelessness?	☐ Yes	☐ No
Are you a health care worker?	☐ Yes	☐ No

Date: _____

Name (to be called) _____Name Listed with Insurance (if different):_____
Pronoun_____ Birthdate _____

Sexual Health & Cancer Screenings

When was your last:			Date	Result	
Cervical Pap Smear	☐ never	☐ unsure	_____		☐ Not applicable
Anal Pap Smear	☐ never	☐ unsure	_____		☐ Not applicable
HIV Test	☐ never	☐ unsure	_____		☐ Not applicable
Sexually Transmitted Infection Test	☐ never	☐ unsure	_____		☐ Not applicable
Hepatitis C Test	☐ never	☐ unsure	_____		☐ Not applicable
Mammogram	☐ never	☐ unsure	_____		☐ Not applicable
Colorectal Cancer Screening	☐ never	☐ unsure	_____		☐ Not applicable
Bone Density Scan	☐ never	☐ unsure	_____		☐ Not applicable
Cholesterol Lab Test	☐ never	☐ unsure			☐ Not applicable

Have you ever been diagnosed with or tested positive for a sexually transmitted infection?

If yes, please check all that apply: ☐ No (Skip this section)

- ☐ HIV/AIDS
- ☐ Gonorrhea
- ☐ Chlamydia
- ☐ Pelvic Inflammatory Disease
- ☐ Not Listed: _____
- ☐ Syphilis
- ☐ Oral Herpes
- ☐ Genital Herpes
- ☐ Genital Warts
- ☐ Trichomonas
- ☐ Bacterial Vaginosis
- ☐ Yeast Infection
- ☐ Molluscum

When was the last time you had sex or came in contact with another person's bodily fluids?
(ejaculate, discharge, blood, or mucous membranes of the mouth, anus, genitals)

_____ ☐ Not applicable

What is your relationship status?

☐ Polyamorous ☐ Non-monogamous ☐ Monogamous ☐ Single, Dating ☐Single, Not Dating

How many regular sexual partner(s) do you currently have? _____ ☐ None

In the past year, how many different sexual partner(s) have you had? _____ ☐ None

How do you practice "safer sex"?_____

As far as you're aware, do any of your sexual partners have a chronic sexually transmitted infection? (HIV, Genital Warts or HPV, Herpes)	☐ Yes	☐ No
Do you think you or your sexual partner(s) may have a contracted a new sexually transmitted infection recently?	☐ Yes	☐ No
Are you having any difficulties with your sex life?	☐ Yes	☐ No

Have you ever had a menstrual period?	☐ Unsure	☐Yes	☐ No (Skip this section)
How old were you when you first got your period? _____			
Do you still have regular periods?	☐ Unsure	☐Yes	☐ No
If no, are you on any medications that stop or affect your period (such as hormones)?	☐ Unsure	☐No	☐ Yes (Skip this section)

What was the date that your last normal period began? _____

What are your periods like?

I get one every _____ days

It lasts for _____ days

On my heaviest day, I use _____ pads/tampons/cups

If you get cramps, how severe are they on a scale of 1 (low) to 10 (high)?_____

Name (to be called) _____Name Listed with Insurance (if different):_____
Pronoun_____ Birthdate _____

Are you capable or have you ever been capable of becoming pregnant? ☐ Yes ☐ No (Skip this section)

Have you ever been pregnant? ☐ Yes ☐ No

If yes, how many times have you:

Been Pregnant? ____ Had an abortion? ____ Had a miscarriage? ____

Had a premature birth? ____ Had a full-term birth? ____ How many live children do you have? ____

Are you planning on getting pregnant in the future? ☐ Unsure ☐ Yes ☐ No

Do you or your partner(s) use any kind of birth control? ☐ Not needed ☐ No ☐ Yes

If yes, what kind? _____ Are you satisfied with this method? ☐ No ☐ Yes

Could you be pregnant today? ☐ Yes ☐ No

Have you or are you currently going through menopause? ☐ Unsure ☐Yes ☐ No (Skip this section)

At what age? _____

Have you had any bleeding since then? ☐ Yes ☐ No

Are you currently having any symptoms of menopause? ☐ Yes ☐ No

If yes, which ones? ☐ Hot flashes ☐ Mood changes ☐ Insomnia ☐ Genital Dryness/Pain with penetration ☐ Not Listed: _____

Mental Health & Substance Use Screening

We ask all clients about safety, depression and substance use, because this can greatly affect your overall health.

Have you ever been non-consensually hit, slapped, kicked, or physically hurt? ☐ Yes ☐ No

If yes, when did this happen? _____

Have you ever been forced or pressured to have sex? ☐ Yes ☐ No

If yes, when did this happen? _____

Do you want to discuss this with your provider today? ☐ Yes ☐ No

Over the past two weeks, how often have you been bothered by:

Having little interest or pleasure in doing things you usually enjoy?

☐ Nearly every day ☐ More than half the days ☐ Several Days ☐ Not at all

Feeling down, depressed, or hopeless?

☐ Nearly every day ☐ More than half the days ☐ Several Days ☐ Not at all

Do you often have trouble sleeping?

☐ Nearly every day ☐ More than half the days ☐ Several Days ☐ Not at all

Do you currently use or have you ever used tobacco products? ☐ Yes ☐ No (Skip this section)

If yes, in terms of tobacco use, are you a:

☐ Current cigarette smoker

When did you first start smoking? _____

How many cigarettes do you smoke per day? _____

Are you interested in quitting? ☐ No ☐ Thinking about quitting ☐ Ready to quit

☐ Former cigarette smoker

When did you quit smoking? _____

On average how many cigarettes did you smoke per day? _____

How many years did you smoke for? _____

☐ Other tobacco user (Circle: cigars, hookah, chew, vape). How often and for how many years?_____

Name (to be called) _____Name Listed with Insurance (if different):_____
Pronoun_____ Birthdate _____

How many times in the past year have you had 4 or more alcoholic drinks in 1 day? _____ ☐ None (Skip this section)

Are you interested in quitting? ☐ No ☐ Thinking about Quitting ☐ Ready to Quit

How many times in the past year have you used a recreational or prescription drug for non-medical reasons? _____ ☐ None (Skip this section)

What have you used and when did you last use?

☐ Marijuana	_____	☐ Methamphetamines (Crystal Meth)	_____
☐ Rx Opioids (Fentanyl, Codeine, Oxycontin, Vicodin, Percocet, Dilaudid, Morphine, etc)	_____	☐ Rx Stimulants (Ritalin, Adderall, Dexedrine, Concerta, etc)	_____
☐ Heroin	_____	☐ Ketamine (Special K)	_____
☐ Cocaine/Crack	_____	☐ Barbiturates (Phenobarbitol)	_____
☐ Cathinones (Bath Salts)	_____	☐ Sleeping Aids (Ambien, Lunesta, etc)	_____
☐ MDMA (Ecstasy)	_____	☐ Rohypnol (GHB)	_____
☐ Phencyclidine (PCP)	_____	☐ LSD (Acid)	_____
☐ Anabolic Steroids or Human Growth Hormone	_____	☐ Mushrooms	_____
☐ Benzodiazepines (Xanax, Klonopin, Ativan, etc)	_____	☐ DMT (Ayahuasca)	_____
☐ Nitrous Oxide (Whippits)	_____	☐ Peyote (Mescaline)	_____
☐ Alkyl Nitrites (Poppers)	_____	☐ Not Listed:_____	_____

If you use opioids, do you have access to Narcan (Naloxone)? ☐ Not Applicable ☐ No ☐ Yes

Are you interested in quitting? ☐ No ☐ Thinking about Quitting ☐ Ready to Quit

Nutrition & Exercise

How many servings per day do you eat:

Fruit? _____ Vegetables? _____ Foods with calcium? _____
(milk, cheese, yogurt, soy milk, tofu, quinoa, greens, etc)

How easy is it for you to access these foods?

☐ Very difficult ☐ Somewhat hard ☐ Easy

How many times per week do you consume the following:

Fast food? _____ Fried food? _____ Sugary drinks? _____
(Soda, juice, sports, or energy drinks, etc)

Do you feel like you eat the right amount of food? ☐ Too little ☐ Too much ☐ The right amount

Are you concerned about your weight? ☐ Yes ☐ No

Do you exercise? ☐ No ☐ Yes

If yes, what do you do? _____

How many times per week? _____How long do you spend working out at a time? _____

Dental History

Have you seen a dentist in the last 6 months? ☐ No ☐ Yes

Do you have difficulty chewing or swallowing? ☐ Yes ☐ No

Do you brush your teeth daily? ☐ No ☐ Yes

Do you floss daily? ☐ No ☐ Yes

Health Directive

Do you have a Missouri Health Care Directive? (a legal document that specifies what actions should be taken if you are no longer able to make decisions for yourself) ☐ No ☐ Yes

Do you have someone to call if you need help in an emergency? ☐ No ☐ Yes

If you are over 50, do you have someone to help you make decisions about your health? ☐ No ☐ Yes

Name (to be called) _____Name Listed with Insurance (if different):_____
Pronoun_____ Birthdate _____

Employment, Housing, & Transportation

Are you working or in school? (Check all that apply)

- ☐ Yes, my current job is: _____
- ☐ No, I'm unemployed
- ☐ No, I'm retired
- ☐ No, I'm on disability for: _____
- ☐ Yes, I'm in school for: _____

What is your current living situation?

- ☐ House or Apartment (Stable/Permanent)
- ☐ With friends/family (Temporary)
- ☐ In a Single Room Occupancy (SRO) Hotel since _____
- ☐ In a Residential Treatment Program
- ☐ In a Vehicle
- ☐ In a Shelter
- ☐ On the Street

Who do you live with? _____

Do you feel safe in your living situation?	☐ No	☐ Yes
If you are over 50 and/or disabled, do you sometimes fall? Is it hard to get up?	☐ Yes	☐ No
Are there guns in your home?	☐ Yes	☐ No
Do you, your friends, or your family smoke in your home or place you live?	☐ Yes	☐ No
Are there working smoke detectors in your home?	☐ No	☐ Yes
Are you a primary caretaker for children, your parents or other adults?	☐ Yes	☐ No
Do you have any pets or a support animal?	☐ Yes	☐ No
When in a car, do you wear a seatbelt?	☐ No	☐ Yes
When riding a motorcycle, do you wear a helmet?	☐ No	☐ Yes
When riding a bicycle, do you wear a helmet?	☐ No	☐ Yes
Have you had any transportation-related accidents recently?	☐ Yes	☐ No
Are family members/friends worried about you driving?	☐ Yes	☐ No

Thank you for taking the time to complete this form!