CENTER FOR INTIMACY HEALTH

INFORM **EDUCATE** **RESTORE**

CLIENT INFORMATION

Client Name: ____

Address: ________________________________| ____________________| ________| __________
city state zip

Phone: Home #____________________ Work #____________________ Cell #____________________

Email Address: ____

Would it be okay to leave a message on your answering machine or voice mail to contact you about appointments? ☐ *Yes* ☐ *No*

Sex: Male ☐ Female ☐

Sexual Identity: Straight or Heterosexual ☐ Lesbian, Gay or Homosexual ☐ Bisexual ☐
Something else ☐ Don't know ☐

Age: ____________ Birthdate: _____________

Race: ____________________ Ethnicity: Non-Hispanic ☐ Hispanic ☐

Preferred Language: ______________________________

Referred by: ____

Primary Care Physician: ____________________________________ Phone #: ______________________

TODAY'S VISIT

What is the reason for your visit today? ____

____

When did the problem(s) first occur: ____

Have you sought help with this problem(s) before? Where? When? ______________________________

What are your top 3 complaints about your General Health and/or Sexual Health?

1. ____________________________________

2. ____________________________________

3. ____________________________________

MEDICAL HISTORY FORM (please check all that apply)

- ☐ Cancer
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Seizures
- ☐ Blood Transfusion
- ☐ Heart Murmur
- ☐ Heart Disease
- ☐ Migraine
- ☐ Asthma
- ☐ IBS
- ☐ Abnormal Pap Smear (Women only)
- ☐ Thrombophlebitis
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Frequent Urinary Tract Infection
- ☐ Depression/Anxiety
- ☐ Gastric Reflux
- ☐ Kidney Stones
- ☐ Thyroid Disease
- ☐ Genital Herpes
- ☐ Chlamydia
- ☐ Gonorrhea
- ☐ Venereal Warts
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Syphilis
- ☐ Sickle Cell Disease or Trait
- ☐ Arthritis
- ☐ Other STD
- ☐ Other medical conditions? ____________________

ALLERGIES, MEDICATIONS, SUPPLEMENTS & SURGERIES

Allergy	**Reaction Type**

Medication (Ex: Claritin)	**Dose** (Ex: 10mg)	**Frequency** (Ex: Twice a day)

Year	**Surgery Type**

List all Supplements: ____

____

FAMILY HISTORY

Do you have a family history of any of the following conditions?

- ☐ Cancer
  If yes, what kind? ☐ Breast ☐ Ovarian ☐ Colon ☐ Prostate ☐ Other
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Osteoporosis

SOCIAL HISTORY

Do you smoke? If yes, how much? ______________________________

Do you drink alcohol? If yes, how much? ______________________________

Do you work outside the home? If yes, what type of work? ______________________________

GYNECOLOGY HISTORY - WOMEN ONLY

Date of Last Pap Smear: ______________________________

Date of Last Mammogram: ______________________________

CHECKLIST FOR WOMEN

Name:________________________________ Date: ____________________

Symptom (please mark)	0 Never	1 Mild	2 Moderate	3 Severe
Depressive Mood (feeling down/sad/lack of drive)	☐	☐	☐	☐
Memory Loss (forgetfulness)	☐	☐	☐	☐
Mental Confusion (feeling in a mental fog)	☐	☐	☐	☐
Decreased Sex Drive/Libido (decreased desire for sex)	☐	☐	☐	☐
Sleep Problems (difficulty falling/staying asleep/wake up tired)	☐	☐	☐	☐
Mood Changes/Irritability	☐	☐	☐	☐
Tension	☐	☐	☐	☐
Migraine/Severe Headaches	☐	☐	☐	☐
Difficult to Climax Sexually	☐	☐	☐	☐
Bloating	☐	☐	☐	☐
Weight Gain	☐	☐	☐	☐
Breast Tenderness	☐	☐	☐	☐
Vaginal Dryness	☐	☐	☐	☐
Hot Flashes	☐	☐	☐	☐
Night Sweats	☐	☐	☐	☐
Dry and Wrinkled Skin	☐	☐	☐	☐
Hair is Falling Out	☐	☐	☐	☐
Cold All the Time	☐	☐	☐	☐
Swelling All Over the Body	☐	☐	☐	☐
Joint Pain	☐	☐	☐	☐

Other symptoms that concern you: ____

____

____

CHECKLIST FOR MEN

Name:___________________________________ Date: _______________________

Symptom (please mark)	0 Never	1 Mild	2 Moderate	3 Severe
Depressive Mood (feeling down/sad/lack of drive)	☐	☐	☐	☐
Memory Loss (forgetfulness)	☐	☐	☐	☐
Feeling Tired and/or Weak	☐	☐	☐	☐
Mental Confusion (feeling in a mental fog)	☐	☐	☐	☐
Mood Changes / Irritability	☐	☐	☐	☐
Loss of Interest in Sex / Libido	☐	☐	☐	☐
Sleep Problems (difficulty falling asleep/staying asleep/wake up tired)	☐	☐	☐	☐
Snoring or Sleep Apnea	☐	☐	☐	☐
Having Trouble Getting an Erection	☐	☐	☐	☐
Having Pain With an Erection	☐	☐	☐	☐
Having Trouble Ejaculating	☐	☐	☐	☐
Feeling Stressed	☐	☐	☐	☐
Feeling Anxious (worry, nervousness, uneasiness, fearful)	☐	☐	☐	☐
Urinating Frequently	☐	☐	☐	☐
Pain with Urination	☐	☐	☐	☐
Blood In Urine	☐	☐	☐	☐

Other symptoms that concern you: ____

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