**Legal Name: Preferred Name: Age: DOB:**

**Are you experiencing any symptoms in the last 2 weeks that you would like to have addressed?**

**Current Medications**

**(Please include dosage & frequency)**

**Medical Conditions Previously Diagnosed**

**Please list any other Current Medical Providers and What they are treating for you.** (example: Dr. Joe Smith – Depression)

**Family History: Who has been diagnosed with?**

**(Please include children, parents and grandparents)**

Heart Disease: Cancer: Diabetes: Stroke: High Blood Pressure:

Other:

**Sex Assigned at birth: Gender Identity: Pronouns: Sexual Identity:**

**Spouse/Partner/Emergency Contact name & number:**

**Occupation: Children(names/ages):**

**Name of Previous PCP: Date of last visit with a PCP:**

Circle all that apply

**Alcohol?** No / Yes ( drinks/week) **Smoke?** Never / Previous ( years quit) / Current ( cigs/day) **Drug use?**

**Which conditions are you seeking care for?** (Please **X** all that apply)

 Transgender Care HIV/AIDS\* Post-exposure prophylaxis (PEP) Pre-exposure prophylaxis (PrEP)\* Low T STDs

 Primary Care Mental Health Care Women’s Care High Blood Pressure ADD/ADHD Preventative Care

 Diabetes Other:

\*For HIV and/or PrEP are you currently on medication for this? Name of medication?

**Exercise routine?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Diet?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous Surgeries/ Hospitalizations (Please include year)**

**Medication Allergies?**

**Please bring a list of all vaccinations, you have received in the last 10 years, to your first visit. (COVID, Tetanus, etc.)**