

Haydee Docasar, M.D.

www.haydeedocasarmd.com

NEW PATIENT HISTORY

I. Identifying Information

Name: _____ DOB: _____ Date: _____

Reason for visit _____

Age: _____ Marital Status: _____ Occupation: _____

Transitioning to (Please Circle): Male to Female Female to Male Years of Transition: _____

Who referred you? _____

Name of internist or family doctor: _____

Spouse/Partner's name: _____ Occupation: _____

List any other physicians or health care providers you see and Specialty:

Name of Psychologist: _____

II. Medical History None

Please list any medical problems that you have. Include Transition History:

Have you had any hospitalization, injuries, fractures or motor vehicle accidents? None

Check if you have or have you ever had:

- | | | |
|--------------------------|--------------------------|---------------------------|
| Alcohol abuse | Anesthetic reaction | Bleeding disorder |
| Asthma | Anemia | Chronic lung condition |
| Blood clots | Drug and substance abuse | Depression/anxiety |
| Diabetes | Heart disease | High blood pressure |
| High cholesterol | Hepatitis/Jaundice | Cancer (Type) |
| Irritable bowel syndrome | Kidney stones | Hypothyroidism |
| Seizure disorder | Stroke | Tuberculosis |
| Stomach ulcers | Mitral valve prolapse | Rheumatic fever |
| Transfusion reaction | Eating disorder | Lupus/autoimmune disorder |

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List all medications that you take with the dose and timing: None

Drug	Dose	Frequency	Reason for medication

List all non-prescription medications that you take regularly including vitamins, herbs and anti-inflammatory medications. Please list type, dose and timing: None

Allergies: List all adverse reactions or allergies you have to medications and what happened. None

III. Surgical History

None

List all surgeries you have had including biopsies.

Date	Operation	Diagnosis

IV. General Health

How much alcohol do you drink/week? None Avg. less than 1/day Avg. 1/day Avg. more ____

Do you smoke? Yes No Amount/day _____ How many years _____

If you quit smoking, when did you stop? _____

Have you used marijuana or other drugs in the last 5 years? Yes No Type: _____