GARY H. GOLDMAN M.D.
Gynecology, Integrative Women's Health, Functional Medicine
435 East 90th Street | New York, NY 10128 | (212) 535-6100 | garygoldmanmd.com

YOU:

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Cell Phone # _____ Alternate # _____

Email _____ Age _____ DOB _____

Social Security # _____ Race _____ Religion _____

Preferred pronoun(s) _____ Sex _____ Gender_____

Occupation _____ Employer _____

Marital Status _____

FAMILY:

Father's Name _____ Mother's Name _____

PARTNER: *(if applicable)*

Name _____ Phone _____

Occupation _____ Employer _____

IN AN EMERGENCY, who should we contact? *(if not your partner)*

Name _____ Relationship _____

Cell Phone # _____ Alternate # _____

INSURANCE:

Insurance Company _____ Policy # _____

Who may we thank for referring you?_____

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Name _____ Age _____ Date of Appointment _____

PERSONAL MEDICAL HISTORY

Check each condition you have and elaborate below

Heart	Arrhythmia	
	Congestive Heart Failure	
	Coronary Artery Disease	
	Elevated Cholesterol	
	Heart Attack	
	High Blood Pressure (HTN)	
	Valve Conditions (MVP, etc.)	
	Other:	
Lungs	Asthma	
	COPD / Emphysema	
	Pneumonia	
	Pulmonary Embolism	
	Other:	
GI	Celiac	
	Crohn's Disease	
	Diverticulitis / Diverticulosis	
	Gall Stones	
	Gastritis / H. pylori	
	GERD / Reflux	
	Hemorrhoids	
	Hepatitis	
	Hiatal Hernia	
	IBS / Diarrhea / Constipation	
	Ulcer	
	Ulcerative Colitis	
	Other:	
Neurology	Alzheimer's	
	Aneurysm	
	Headaches / Migraines	
	Parkinson's	
	Seizures / Epilepsy	
	Stroke	
	Other:	
Hormones	Diabetes	
	Prolactin	
	Thyroid	
	Other:	

Urology	Incontinence of Urine	
	Interstitial Cystitis (IC)	
	Kidney Stones	
	Pyelonephritis	
	UTIs	
	Other:	
Eyes & ENT	Glaucoma	
	Macular Degeneration	
	Sleep Apnea	
	Tonsils / Ear / Sinus Infections	
	Other:	
Hematology	Anemia	
	DVT / Phlebitis	
	Hemophilia / von Willebrand's	
	Sickle Cell / Thalassemia	
	Thrombophilia	
	Transfusion History	
	Other:	
Muscles &	Arthritis	
Bones	Fractures	
	Hernia	
	Herniated Disc	
	Osteoporosis / Osteopenia	
	Other:	
Rheumatology	Ehlers-Danlos / Marfan's	
	Lupus	
	Sjogren's	
	Other:	
Cancer		
Genetics		
Infections		
Psychiatric		
Skin Issues		
	Additional Issues	

_____

_____

_____

_____

FAMILY MEDICAL HISTORY

Check each condition present in your family members and elaborate below

Heart	Arrhythmia	
	Congestive Heart Failure	
	Coronary Artery Disease	
	Elevated Cholesterol	
	Heart Attack	
	High Blood Pressure (HTN)	
	Valve Conditions (MVP, etc.)	
	Other:	
Lungs	Asthma	
	COPD / Emphysema	
	Pneumonia	
	Pulmonary Embolism	
	Other:	
GI	Celiac	
	Crohn's Disease	
	Diverticulitis / Diverticulosis	
	Gall Stones	
	Gastritis / H. pylori	
	GERD / Reflux	
	Hemorrhoids	
	Hepatitis	
	Hiatal Hernia	
	IBS / Diarrhea / Constipation	
	Ulcer	
	Ulcerative Colitis	
	Other:	
Neurology	Alzheimer's	
	Aneurysm	
	Headaches / Migraines	
	Parkinson's	
	Seizures / Epilepsy	
	Stroke	
	Other:	
Hormones	Diabetes	
	Prolactin	
	Thyroid	
	Other:	

Urology	Incontinence of Urine	
	Interstitial Cystitis (IC)	
	Kidney Stones	
	Pyelonephritis	
	UTIs	
	Other:	
Eyes & ENT	Glaucoma	
	Macular Degeneration	
	Sleep Apnea	
	Tonsils / Ear / Sinus Infections	
	Other:	
Hematology	Anemia	
	DVT / Phlebitis	
	Hemophilia / von Willebrand's	
	Sickle Cell / Thalassemia	
	Thrombophilia	
	Transfusion History	
	Other:	
Muscles &	Arthritis	
Bones	Fractures	
	Hernia	
	Herniated Disc	
	Osteoporosis / Osteopenia	
	Other:	
Rheumatology	Ehlers-Danlos / Marfan's	
	Lupus	
	Sjogren's	
	Other:	
Cancer		
Genetics		
Infections		
Psychiatric		
Skin Issues		
	Additional Issues	

Please indicate for each: Alive / Deceased, Age currently or at time of death, and any known health conditions

Mother_____

Father_____

Mother's Mother_____

Mother's Father_____

Father's Mother_____

Father's Father_____

Sister(s)_____

Brother(s)_____

Daughter(s)_____

Son(s)_____

Aunt(s)_____

Uncle(s)_____

MEDICATIONS

Name	Dose	Frequency	Indication

SUPPLEMENTS / VITAMINS

_____

_____

_____

_____

ALLERGIES

Medication/Substance	Reaction

SURGICAL HISTORY

Date	Procedure	Indication	Surgeon	Location

SOCIAL HISTORY - *Please elaborate*

Diet _____

Exercise _____

Sleep _____

Stress Management _____

Relationships _____

Safety _____

Cigarettes _____

Alcohol _____

Recreational Drugs _____

HEALTH MAINTENANCE

When was your last annual bloodwork _____ Who performed this for you? _____
Have you been tested for HIV? _____ Results: _____ Date: _____
Have you been tested for Hepatitis C? _____ Results: _____ Date: _____
When was your last Colonoscopy? _____ Results: _____ Date: _____
Have you had a Cologuard test? _____ Results: _____ Date: _____
Have you had a DEXA Bone Density test?_____ Results: _____ Date: _____

VACCINES – Note the date of your most recent vaccines

Flu _____ COVID _____ TDAP _____
Gardasil _____ Shingles _____ Pneumonia _____

SEXUAL HEALTH

Have you ever had sex? _____ Are you currently having sex? _____
Current: # of partners____ Male___ Female___ Other___ Present method of contraception (if any)_____
Lifetime: # of partners____ Male___ Female___ Other___ Previous method(s) of contraception_____

Have you ever been sexually assaulted? _____ Do you feel safe with your current partner? _____
Do you have any current sexual concerns? _____

Have you ever been diagnosed with a sexually transmitted disease? _____
Have you ever had:
Oral Herpes_____ Genital Herpes_____ Other Herpes_____ A positive Herpes blood test without a history of an outbreak_____
Genital warts_____ HPV (Human Papilloma Virus)_____ Molluscum Contagiosum_____
Syphilis_____ Gonorrhea_____ Chlamydia_____ Trichomonas_____ PID (Pelvic Inflammatory Disease)_____

MALE SEXUAL HEALTH – *if applicable*

Any problems with
Libido _____ Erections _____ Orgasms _____ Prostate Infection _____ Poor Urinary Stream _____

FEMALE SEXUAL HEALTH – *if applicable*

Any problems with
Libido_____ Lubrication_____ Orgasms_____ Pain_____ Bleeding_____ Penetration _____
Have you ever been treated with ThermiVa or MonaLisa? _____

MENSTRUAL HISTORY

Age at first period _____ First day of most recent period _____ First day of prior period _____

How often do your periods occur? (*average is every 28 days*) _____
How regular/irregular are your cycles – *please describe:* _____
How many days do your periods last? _____ How heavy is your flow? _____
How are your menstrual cramps? _____ Do you cramp with ovulation? _____
Do you bleed between cycles – *please describe:* _____

At what age did your mother or other female relatives start menopause, if known: _____

If you are menopausal, are you now using Hormone Replacement Therapy (HRT)? _____
What regimen are you using? _____
Have you used HRT previously? _____ Are you interested in discussing HRT? _____

GYNECOLOGICAL HISTORY

When was your last Pap smear? _____ Results, if known _____
When was your last HPV test? _____ Results, if known _____
Have you ever had an abnormal Pap smear or a positive HPV test – *please describe:* _____
Have you ever had a Colposcopy for an abnormal Pap? _____ Results: _____
Have you ever been treated for an abnormal Pap or for HPV? _____
Have you had any of the following: Cryosurgery / Freezing _____ Laser _____ LEEP _____ Cone Biopsy _____

Do you have a history of endometriosis _____ adenomyosis _____ uterine fibroids _____
PCOS _____ ovarian cysts _____ infertility _____
eating disorder _____ DES exposure _____

VAGINAL INFECTIONS

Have you had vaginal yeast infections _____ How many _____ How often do they occur_____
Have you had vaginal bacterial infections (BV / Bacterial Vaginosis)_____ How many_____ How often do they occur_____
Have you had other types of vaginal infections *(specify)* _____
Have these been treated by symptoms only or based on a lab culture? _____
What therapies have you used in the past _____

BREAST HEALTH

Do you have current breast concerns? _____
Do you have: a mass _____ localized pain _____ new nipple inversion _____
new skin retraction _____ new skin redness _____ enlarged armpit lymph nodes _____
nipple discharge _____ other _____

When was your last mammogram? _____ What were the results? _____
When was your last breast sonogram? _____ What were the results? _____
When was your last breast MRI? _____ What were the results? _____
Have you had a breast biopsy? When? _____ What were the results? _____
Do you have a family history of breast cancer or ovarian cancer? _____
Have you or other family members had genetic testing such as a BRCA test? _____

OBSTETRICAL HISTORY

How many times have you been pregnant? _____ Number of live children _____
Number of miscarriages _____ Number of terminations _____ Number of ectopic pregnancies _____

Date	Vaginal or Cesarean	Sex	Weight	Term or Premature	Complications
OK					

ANY OTHER CONCERNS - Use this space to share with us additional health issues not addressed elsewhere.

_____
_____
_____
_____
_____
_____
_____

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PATIENT PHARMACY INFORMATION

Please provide our office with your pharmacy contact information, including alternative pharmacy and mail order pharmacy information. Include the name, street address, zip code and phone number, as this information is crucial for all E-Prescribing.

Patient Name _____ Date of Birth _____

Pharmacy #1

_____
Name
_____
Address
_____

_____
Phone

Pharmacy #2

_____
Name
_____
Address
_____

_____
Phone

Pharmacy #3

_____
Name
_____
Address
_____

_____
Phone

Mail Order Pharmacy

_____
Name
_____
Address
_____

_____
Phone

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Assignment and Release

I, the undersigned, certify that I (or my dependent) have (has) insurance coverage with the Insurance Company _____ and assign directly to Gary H. Goldman, MD all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not payable by insurance. I hereby authorize Gary H. Goldman, MD to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Responsible Party Name Signature

_____ _____

Relationship to Patient Today's Date

HIPPA Signature

Notice of Privacy Practices Acknowledgement

By my signature below, I acknowledge that I have received the Notice of Privacy Practices and have been provided an opportunity to review it.

_____ _____

Name Signature

_____ _____

Date of Birth Today's Date

PRINT