 INTAKE SHEET FOR RETURNING PATIENTS- ANNUAL VISITS

Patient Name: ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gynecological History:**

What do you use to prevent pregnancy? (please circle)

None Menopause Pill IUD Condoms Depo Provera

Nuva Ring Nexplanon Tubal Sterilization Vasectomy Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you sexually active? Yes No Not Currently If yes, active with? Men Women Both

Are you still having periods? No / Yes- when was the first day of your last period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long do they last? \_\_\_\_\_\_\_\_ days Period flow (please circle) light moderate heavy

How far apart are your periods (from 1st day of period to start of next period)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any problems currently with your period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pregnancy History:**

Total number of pregnancies \_\_\_\_\_\_\_\_\_\_\_\_ Number of ectopic pregnancies \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of live births \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of elective terminations \_\_\_\_\_\_\_\_\_\_\_\_\_

Number of living children \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of adopted children \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of miscarriages \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications:** list all current including supplements (or give list to nurse)

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What medications do you need refilled today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What pharmacy do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies:**

Known allergies? No / Yes- please specify including reaction \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Latex allergy? No / Yes

**Social History:**

Do you feel safe in your home? Yes / No

Marital status (please circle) single married divorced widowed

Highest level of education (please circle)

high school/GED some college 2 year college degree 4 year college degree postgraduate

What is your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you get calcium? No / Yes- please specify (i.e. dairy, supplements, both) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­

Number of caffeine drinks per day (8oz= 1 drink) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many times do you exercise per week? \_\_\_\_\_\_\_\_ Type of exercise \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you drink alcohol? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recreational drug use (i.e. Marijuana, Methamphetamine, etc.) none previous current

\* If current use, please specify ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your smoking status? (please circle) never smoked former smoker current smoker

\* If current smoker- what type of tobacco products do you use? (please circle)

cigarettes electronic cigarettes/vaping smokeless tobacco

**Medical history:**

Any changes in medical history since your last visit? (i.e. new/change in medical diagnosis) Yes / No

\* If yes, please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Surgical history:**

Any new surgeries since your last visit? Yes / No

\* If yes, please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family history:**

Any changes in family history since your last visit? (i.e. new medical diagnosis) Yes / No

\* If yes, please specify including family member affected \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Depression screening:**

Over the past 2 weeks, please answer how often you have been bothered by the following problems?

1. Little interest or pleasure in doing things? (please circle)

not at all (0) several days (1) more than half the days (2) nearly every day (3)

1. Feeling down, depressed, or hopeless? (please circle)

not at all (0) several days (1) more than half the days (2) nearly every day (3)

***\* Please answer the following questions if you are 65 years of age or older:***

**Risk for falls:**

Have you had 2 or more falls in the past year? Yes / No

Have you had an injury due to a fall in the past year? Yes / No

**Advanced Directive/Living Will:**

Do you have an Advanced Directive/Living Will? Yes / No

If no, would you like to discuss or get information about an Advanced Directive/Living Will? Yes / No