NAME: _____ BIRTH DATE: _____ DATE: _____

GYNECOLOGIC PATIENT INTAKE HISTORY

ALLERGIES: (Include type of reaction) ☐ No Known Drug allergies ☐ LATEX ALLERGY ☐ Iodine/Shellfish

Family Physician _____

GYNECOLOGICAL HISTORY:

☐ Premenopausal
- Age at first menstrual period _____
- Date your last period started _____
- How often are your periods? _____
- Are your periods regular? YES NO
- How many days do you usually flow? _____
- Is your flow light, moderate or heavy? _____
- Do you have PMS symptoms? YES NO
  If yes, describe:
- History of ovarian cysts? YES NO
- History of infertility? YES NO

☐ Postmenopausal
- On hormonal replacement? YES NO
  If no, why not?
- Any vaginal bleeding or spotting? YES NO
- Any hot flashes, night sweats, vaginal driness? YES NO

☐ Had Hysterectomy
- When/Where _____
- Reason _____
- Were your ovaries removed also? YES NO

- Date of last Pap smear: ___/___/___
- Any abnormal results? YES NO
  If yes, when and what was the treatment?
- Date of last mammogram: ___/___/___
- Any abnormal results? YES NO
- Do you do monthly self breast exams? YES NO

Sexual History
- Are you currently sexually active? YES NO
  # partners in last 12 months _____
  # partners in your lifetime _____
- Pain during or after intercourse? YES NO
  Describe:
- Current birth control method: _____
  Have you ever used pills/patch/ring? YES NO
  Describe any side effects:
- Do you use condoms regularly? YES NO
- History of sexually transmitted diseases? YES NO
  Gonorrhea Herpes Trichamonas
  Chlamydia Genital warts Other:
- History of tubal/pelvic infections YES NO
  Were you hospitalized?

OBSTETRICAL HISTORY: (Please list all deliveries in chronological order)

• Total number of pregnancies: _____ • Number of miscarriages/abortions: _____ • Number of Living Children: _____

YEAR	HOSPITAL/PHYSICIAN	WEIGHT	SEX	TYPE OF DELIVERY	COMPLICATIONS

SURGERIES/HOSPITALIZATIONS: (Please list all surgical procedures AND hospital admissions in chronological order)

Include all surgeries -- tonsillectomy, appendectomy, cholecystectomy, D&C, tubal ligations, C-Sections, plastic surgery, major dental procedures, etc.

YEAR	HOSPITAL/PHYSICIAN	PROCEDURE/DIAGNOSIS	COMPLICATIONS

PAST MEDICAL HISTORY: Please check all that apply

☐ Asthma
☐ Allergies/Hayfever
☐ Tuberculosis
☐ Pneumonia
☐ High Blood Pressure
☐ Stroke
☐ Heart trouble
☐ Anemia/Blood Transfusions
☐ Gastric Ulcers/GERDS
☐ Irritable Bowel Syndrome
☐ Kidney Infections/Stones
☐ Hepatitis
☐ Blood Clots
☐ Thyroid Disease
☐ Diabetes
☐ Cancer
☐ Depression/Anxiety
☐ Seizure Disorders
☐ OTHER: _____

NAME: _____ AGE: _____ DATE: _____

CURRENT MEDICATIONS: (Including birth control pills, vitamins, herbs, supplements, otc and herbal medications)

MEDICATION	DOSAGE/FREQUENCY	REASON	HOW LONG?

SOCIAL HISTORY:

HABITS Tobacco YES NO Type / Amount
Alcohol YES NO Type / Amount
Drugs YES NO

☐ Regular Exercise _____
☐ Special Diet _____
Do you diet frequently? YES NO
Have you ever vomited to lose weight? YES NO
What did you weigh a year ago? _____
What is the most you ever weighed? _____

PERSONAL PROFILE

☐ Single Partner: ☐ male ☐ female ☐ both
☐ Married Spouse's Name _____
☐ Widowed Number of people in household _____
☐ Divorced

☐ Student Grade/Year _____
School _____
☐ Current employment:

FAMILY HISTORY: Please indicate illnesses listed below for each family member. If deceased, indicate age and cause.)

ILLNESSES: Heart disease, high blood pressure, diabetes, cancer, asthma, emphysema, tuberculosis, liver disease, thyroid disease, kidney disease, osteoporosis, stroke, blood clots

FATHER _____
MOTHER _____
SIBLINGS _____
_____
_____

MATERNAL GRANDMOTHER _____
MATERNAL GRANDFATHER _____
PATERNAL GRANDMOTHER _____
PATERNAL GRANDFATHER _____
OTHER _____

REVIEW OF SYSTEMS:

	NOW	PAST
CONSTITUTIONAL		
Weight loss / gain	☐	☐
Fatigue	☐	☐
PSYCHIATRIC		
Memory loss/Confusion	☐	☐
Nervousness/Anxiety	☐	☐
Depression/Crying	☐	☐
Sleep disturbances	☐	☐
HEENT		
Vision changes	☐	☐
Sinus problems	☐	☐
Dental problems	☐	☐
CARDIOVASCULAR / RESPIRATORY		
Chest pain	☐	☐
Difficult breathing	☐	☐
Swelling of legs	☐	☐
Heart palpitations	☐	☐
Wheezing	☐	☐
Shortness of breath	☐	☐
Chronic cough	☐	☐

	NOW	PAST
BREASTS / SKIN		
Pain in breast	☐	☐
Nipple discharge	☐	☐
Breast mass	☐	☐
Rash / Ulcers	☐	☐
Change in moles	☐	☐
Change in hair patterns	☐	☐
GASTROINTESTINAL		
Diarrhea	☐	☐
Bloody stool	☐	☐
Nausea / Vomiting	☐	☐
Constipaiton	☐	☐
GENITOURINARY		
Burning on urination	☐	☐
Blood in urine	☐	☐
Urgency	☐	☐
Frequency	☐	☐
Incomplete emptying	☐	☐
Incontinence	☐	☐
Painful intercourse	☐	☐

	NOW	PAST
MUSCULOSKELETAL		
Muscle weakness	☐	☐
Arthritis	☐	☐
Difficulty walking	☐	☐
Back pain	☐	☐
NEUROLOGICAL		
Dizziness	☐	☐
Seizures	☐	☐
Numbness	☐	☐
ENDOCRINE / HEMATOLOGIC		
Hormonal problem	☐	☐
Heat / Cold intolerance	☐	☐
Dry skin	☐	☐
Enlarged glands	☐	☐
Easy bruising	☐	☐
Slow to heal cuts	☐	☐
IMMUNIZATIONS		
Last tetanus vaccine		_____
Last Flu vaccine		_____
Pneumococcal Vaccine		_____

FOR OFFICE USE ONLY:

Information reviewed by Provider on ____/____/____

Form completed by: ☐ Patient
☐ Relative
☐ Office staff (_____)
Initials

_____
PROVIDER'S SIGNATURE