DATE: ___________________________

# PATIENT INTAKE FORM
## All for Women Healthcare, S.C.

**PLEASE FILL-IN THIS FORM AS COMPLETELY AS POSSIBLE — PRINT LEGIBLY**

*Your answers on this form will help us better understand your medical concerns and conditions. If you are uncomfortable with any questions, leave them blank. You can discuss them personally with Dr. Tam. If you cannot remember specific details, please provide as much as you can remember. This information will only be used for clinical purposes and remains completely private.*

First Name: ______________________________ M.I.: _____ Last Name: ____________________________________________

Address: ____________________________________________________________________________________________

City: ____________________________________________________________ State: __________ Zip: ___________________

Phone: (_____) ______________________________ email: ________________________________________________________

Preferred contact method (√ one) : ___ phone ___ email ___either

Date of Birth: ________________ Age: __________ Insurance: ___________________________________________________

Name of Insured: ______________________________ ID #: _________________________ Group #: ___________________

Pharmacy: _______________________ Location: ______________________________________ Phone: (____) ______________

How did you hear of our practice? ___ Internet search ___Our website ___ZocDoc Other: ______________________

Referred by: ___ Friend ___ Doctor ➔ Name: _______________________________________________________________

SELECT ONE (√): ___NEW PATIENT ___PREVIOUS PATIENT (transferring) ___CURRENT PATIENT

Why are you here today? ___Yearly Exam _____ Pregnancy Other reason: ________________________________________

### I – OB HISTORY (*PREGNANCIES*)

1. Have you ever been pregnant (√) ? ___**YES** (successful) ➔ # Vaginal____ #Cesarean:____ # of children ____

___**YES** (unsucessful) ➔ # Miscarriage(s):____ # Abortion(s):_____ ____ **NO** (Never been pregnant)

### II – GYNECOLOGIC HISTORY

1. What was the first day of your most recent menstrual period? ___/___/_____ ___**Menopause** (skip to question 2)
   - What age did you start having your periods (menses)? _______ years old
   - What is the average length (days) of your menstrual period? ________days
   - How many days between periods? ___________days
2. Are you sexually active? ___YES ➔ Sexual parters are: ___male ___female ___both
   ___NO, not sexually active
3. What contraception method do you use to prevent pregnancy? ______________________________ [ ___Not applicable]
4. Have you ever been treated for any of these sexually transmitted infections (STI)? :
   ___Herpes ___Chlamydia ___Gonorrhea ___Syphilis ___Trichomonas
   ___Pelvic inflammatory disease ___Genital warts and/or HPV ___Bacterial vaginitis ___HIV/AIDS
5. Do you want to be screened for STI's today? ___YES ___NO
   *[NOTE: We routinely screen all women under 26 years old per the American College of Obstetrics and Gynecology (ACOG) guidelines. Please let us know if you do not want to be screened.]*
6. When was your last PAP smear? ____/____/____(date) ➔ Result: ___Normal ___Abnormal (answer next questions)
   If PAP was abnormal, what was the finding? ___________________________________________________________
   What was the treatment (if any)? ___________________________________________________________________
7. Have you ever had an abnormal PAP? ___NO ___YES ➔ Treatment: ____________________________________)
8. Have your received the HPV (human papilloma virus) vaccine? ___NO ___YES ➔ Date: _________
9. Have you ever had a mammogram? ___NO ___YES ➔ Date: ___/___/_____ [ ___Not Applicable]

### III – PERSONAL MEDICAL HISTORY

1. Do you have any allergies? ___NO ___YES ➔ List: ____________________________________________________
   If "YES", describe allergic reaction: _______________________________________________________________
2. Are you on any Medications?: ___NO _____YES ➔ List: ________________________________________________
3. Any reaction to medications? ___ NO _____YES ➔ Which and reaction: ___________________________________
4. Any medical problems? ___NO ___YES ➔ List: ______________________________________________________
5. Family history of medical problems? ___NO ___YES ➔ Describe w/relationship: _____________________________
   _________________________________________________________________________________________
6. Any surgeries? ___NO ___YES ➔ List w/date: _______________________________________________________
7. Have you had a flu shot? ___YES ➔ Date: ________________________ Where?: __________________________
   ___NO ➔ Reason: ___ I plan to get one ___ I do not want one ___Allergic Other: ___________________

Patient Initials: ___________

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Date: ____________________________

**All For Women Healthcare, S.C. – PATIENT INTAKE FORM**

First Name: ______________________________ M.I.: _____ Last Name: __________________________________ DOB: _________________

## IV – SOCIAL HISTORY

**PLEASE PRINT LEGIBLY**

1. **TOBACCO USE:** Do you smoke cigarettes? ___NO ➔ ___Never smoked ___Quit (when? _____/_____/_____)
   ___YES ➔ ______ packs/day ______ years Other tobacco products used: ______________________
2. **ALCOHOL USE:** Do you drink alcohol? ___NO ___YES ➔ Number of drinks/week: ________________________
   ➔ Have you ever blacked-out from use of alcohol? ___NO ___YES
   ➔ Is your alcohol use a concern for you or others? ___NO ___YES
3. **DRUG USE:** Do you use recreational drugs? ___NO ___YES ➔ List drugs used: ________________________
4. **HAVE YOU EVER BEEN ABUSED?** ___NO ___YES ➔ Describe: ________________________________________
5. **DO YOU WEAR SEATBELTS WHEN RIDING IN A MOVING VEHICLE?** ___YES ___NO
6. **DIET & EXERCISE** *(Briefly describe)*: ____________________________________________________________

   ________________________________________________________________________________

## V – BACKGROUND HISTORY

1. **ETHNICITY:** ___ Caucasian | ___ African American | ___Hispanic | ___Asian/Pacific Islander | Other _______________
2. **EMPLOYMENT**
   Are you employed? ___Full time ___Part time ___Unemployed ___Self-employed ___Retired
   Occupation: ________________________________ Employer: ____________________________________________
3. **EDUCATION**
   HIghest Degree(s) earned: ___High school ___Trade/Associate ___Undergrad ___Graduate ___Post Grad
4. **MARITAL STATUS**
   ___Single ___Married/Partner ___Divorced ___Widowed Other: _________________________

## VI – REVIEW OF SYSTEMS *(Please check any symptoms you may be having)*

| | | |
|---|---|---|
| *1.* | *Constitutional:* | *___Fever/chills/excessive sweating \| ___Unexplained weight loss/gain/fatigue \| Other: ______________* |
| *2.* | *Gastrointestinal:* | *___Abdominal pain \| ___Nausea/vomiting/diarrhea \| ___Constipation \| ___Bloody stools* |
| *3.* | *Eyes/ears/nose/throat:* | *___Vision changes \| ___Hearing loss \| ___mouth breathing/snoring \| ___ringing in ears<br>___difficulty hearing \| ___hay fever/allergies/congestion \| Other: _________________________* |
| *4.* | *Genitourinary:* | *___Concern with sexual function \| ___Vaginal discharge \| ___Painful or blooody urination<br>___ Incontinence \| Other: ______________________________________________________* |
| *5.* | *Cardiovascular:* | *___ Shortness of breath \| ___Palpitations \| Other: ________________________________________* |
| *6.* | *Skin:* | *___Rashes \| ___New or change in a mole \| ___Acne \| Other: _______________________________* |
| *7.* | *Psychiatriatric:* | *___Anxiety/depression \| ___Insomnia/nightmares \| ___Bad temper/anger/rage \| Other: ___________* |
| *8.* | *Blood/lymphatic:* | *___Unexplained lumps or bumps \| ____Bruise easily/bleeding \| Other: ______________________* |
| *9.* | *Respiratory:* | *___Coughing \| ___Wheezing \| ___Difficulty breathing \| Other: ____________________________* |
| *10.* | *Neurological:* | *___Headaches \| ___Fainting \| ___Memory loss \| Other: _________________________________* |
| *11.* | *Musculoskeletal:* | *___Muscle/joint pain \| ___Muscle/joint edema \| ___Recent back pain \| Other: __________________* |
| *12.* | *Breasts:* | *___Lumps or masses \| ___Nipple discharge \| ___Painful breasts \| Other: ____________________________* |

*PATIENT CONSENT TO TREATMENT: I hereby acknowledge that all above information is true and accurate to the best of my knowledge. I herby authorize such medical care, treatment, and diagnostic tests as may be recommended and understand there is no warranty or guarantee of result or cure. This consent will remain in effect until I withdraw my consent in writing.*

Patient Signature: ______________________________________________________________ Date: __________________

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