GYNECOLOGIC INTAKE HISTORY

Patient Name_____ Today's Date _____/_____/_____

Phone #s Home_____ Date of Birth _____/_____/_____ Age _____

Work_____ Name of Spouse/Partner _____

Cell _____ Referred by _____

PATIENT'S MEDICAL HISTORY – Please circle if you have/had any of these problems

Anemia/Blood Transfusion	Diabetes	High Blood Pressure	Psychiatric Problems
Arthritis/Joint Pain	Epilepsy/Neurological Problems	High Cholesterol	Skin Disorder
Asthma/sinus/Allergies	Fracture	Kidney Disease/Problems	Stroke
Birth Defects/Hereditary Problems	Gastrointestinal	Lung Disease	Thyroid Disease
Bleeding Disorder	Glaucoma/Eye Problems	Major Accidents	Tuberculosis
Cancer (Type(s): _____	Heart Trouble	Mitral Valve Prolapse	Other (specify on back)
Age diagnosed: ____)	Depression/Anxiety	Hepatitis/Liver Disease	Osteoporosis
Migraine Headaches			

CURRENT MEDICATIONS – Please list. Use back of paper if needed.

Drug Name & Dosage	Drug Name & Dosage
1.	4.
2.	5.
3.	6.

OPERATIONS/HOSPITALIZATIONS – Please use back of paper if needed.

Date	Reason	Date	Reason

GYNECOLOGIC HISTORY

Last Pap Smear – Date: _____ Doctor: _____Facility: _____

Last Mammogram – Date: _____ Facility: _____

Last DEXA Bone Scan – Date: _____ Facility: _____ Last Colonoscopy – Date: _____

Gardasil/HPV Vaccine Completed: ☐ Yes ☐ No

Age of first period: _____ Time Between Periods: _____ Duration of flow: _____Days Flow: Light – Moderate – Heavy

Age onset of menopause: _____

Current Contraception: ☐ Pills ☐ IUD ☐ Depo-Provera ☐ Implant ☐ Tubal Ligation ☐ Vasectomy ☐ Other:_____

Do you have any of the following? Please check if yes.

☐ Uterine Fibroids ☐ History of infertility ☐ Ovarian cysts ☐ Endometriosis ☐ Incontinence

☐ History of STD ☐ Herpes ☐ HPV ☐ History of abnormal pap

☐ History of abnormal mammogram ☐ History of pelvic infection ☐ History of breast biopsy

OB HISTORY (number)

Pregnancies _____

Births _____

Miscarriages _____

Abortions _____

Living Children _____

Pregnancies (Please complete as much as possible)

Delivery Year	Sex & Weight	Hospital	Complications

SOCIAL HISTORY

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Current Occupation: _____ School Completed: ☐ High School ☐ College ☐ Graduate Degree

Number of people living in household: _____ ☐ Other _____

Smoking ☐ yes ☐ no #packs per day _____ # years smoking _____ date quit_____

Alcohol ☐ yes ☐ no # drinks per day _____ or # drinks per week _____

Drug Use ☐ yes ☐ no If yes, what? _____ if yes, how often? _____

Regular exercise ☐ yes ☐ no

Do you have an advanced directive (also known as a living will)? ☐ yes ☐ no (Please provide a copy to the office)

Last immunization or test	**Date**	**ALLERGIES (List & type of reaction)**	
Shingles			
Flu Shot			
Pneumonia			
TB Skin Test			

(OVER)

FAMILY HISTORY

☐ I am adopted and do not know my family history.
☐ I am unable to get my complete family history.

Family Member	Age	Alive/Deceased	Medical Problems	Cause of Death
Father				
Mother				
(Siblings)				

Do any relatives (Parents, siblings, your children, aunts, uncles, grandparents, etc.) have any of these conditions?

Condition	Yes	No	Relative & Age of Diagnosis	Condition	Yes	No	Relative & Age of Diagnosis
Breast Cancer				High Blood Pressure			
Ovarian Cancer				Osteoporosis			
Colon Cancer				Drinking Problem			
Uterine Cancer				Stroke			
Other Cancer Type(s): _____ _____				Thyroid Disease			
				Heart Disease			

Have you or any of your relatives had genetic testing? ☐ yes ☐ no
Are you of Ashkenazi Jewish descent? ☐ yes ☐ no
Are you concerned about your personal and/or family history of cancer? ☐ yes ☐ no

REVIEW OF SYSTEMS (circle all that apply to you currently or recently)

☐ I am having none of the following symptoms

CONSTITUTIONAL
Weight Loss Weight Gain Fever Poor Appetite
Fatigue Trouble Sleeping Night Sweats

ALLERGY/IMMUNE SYSTEM
Seasonal Allergies Difficulty Healing Steroid Use
New Drug Allergy Frequent Illness

EYES
Vision Changes Burning Glaucoma
Double Vision Eye Pain

NEUROLOGICAL
Numbness Dizziness Difficulty Walking
Headaches/Migraines Seizures Tingling

EARS/NOSE/THROAT/MOUTH
Ear Aches Sinus Problems Mouth Sores Nosebleeds
Ringing in Ears Sore Throat Dental Problems

PSYCHIATRIC
Depression Disorientation Anxiety Sleep Disturbances
Excessive Mood Swings Frequent Crying Spells

CARDIOVASCULAR
Chest Pain/Angina Palpitations Irregular Heart Beat
Difficulty Breathing on Exertion Leg Pain Swelling of Legs

ENDOCRINE
Dry Skin Excessive Thirst Hot Flashes Hair Loss
Absence of Periods Irregular Periods Cold Intolerance

RESPIRATORY
Cough Shortness of Breath Wheezing
Pain with Breathing Coughing up Blood

HEMATOLOGIC/LYMPHATIC
Anemia Swollen Glands Enlarged Lymph Nodes
Easy Brusiability Cuts do not stop bleeding

GASTROINTESTINAL
Nausea/Vomiting Diarrhea Bloating
Bloody or Black Stools Constipation Hemorrhoids
Change in Stools Abdominal Pain

MUSCULOSKELETAL
Muscle Pain Joint Pain Arthritis
Muscle Weakness Back Pain Osteoporosis
Osteopenia

GENITOURINARY
Burning with Urination Incontinence Abnormal Periods
Blood in Urine Urgency Painful Intercourse
Increased Frequency of Urination Vulvar/Vaginal Lump
Vulvar/Vaginal Itching or Swelling

BREAST/SKIN
Breast Lump Milky Breast Discharge Rash
Breast Pain New Skin Lesion Ulcers
Breast Discharge Change in Moles

PERSONAL SAFETY

Has anyone close to you ever threatened you? ☐ yes ☐ no
Has anyone ever hit, kicked, choked, or hurt you physically? ☐ yes ☐ no
Has anyone, including your partner, ever forced you to have sex? ☐ yes ☐ no
Are you afraid of your partner? ☐ yes ☐ no

Completed by: ☐ Patient ☐ Office Nurse ☐ Physician

Signature of Patient _____

Physician Signature_____ Date reviewed_____