NEW GYNECOLOGIC PATIENT INTAKE HISTORY

Patient Name & Preferred Pronouns:	Age:	Birth date:	Date form completed:
Referred by:		Primary care provider:	
What brings you to the office today?			
Is this a new problem? ☐ yes ☐ so			
Please describe your problem, including where it is, how severe it is, and how long it's lasted. What Pharmacy do you use? (Name/Number/Location)			

ALLERGIES

To what?	What happened? (i.e. itching, rash, trouble breathing)	When?

OBSTETRIC HISTORY

	Number		Number		Number
Pregnancies:		Abortions:		Miscarriages:	
Premature births (<37 weeks)		Live births:		Living children:	

No.	Birth date	Birth weight	Baby's sex	Weeks pregnant	Type of delivery (vaginal, cesarean, etc.)	Complications
1						
2						
3						
4						
5						

GYNECOLOGICAL HISTORY

First day of last normal menstrual period:	Present method of birth control:
Age periods began: If Menopausal: Age periods stopped	Have you ever used an intrauterine device (IUD)? For how long?
Length of periods (# of days of bleeding) If Menopausal: Have you had any spotting since?	Have you ever used birth control pills? For how long?
Number of days between periods (if you are still having periods):	When was your last pap test?
Any recent changes in period (If still having periods)?	What was the result?
Have you ever had sex?	Do you do regular breast self examinations?
Are you currently sexually active?	Have you ever had an abnormal Pap result? When/where?
Are your partner(s): ☐ male? ☐ female? ☐ both?	Have you had the 3 shot series of the Gardasil (HPV) vaccine?

PERSONAL PROFILE

Marital status: ☐ married ☐ living with partner ☐ single ☐ widowed ☐ divorced
Number of people in household:
School completed: ☐ high school ☐ some college/AA degree ☐ college ☐ graduate degree ☐ other _____
Recent Travel outside the US? ☐ yes ☐ no If yes, where/when?

Name_____ **Birth date** _____

SOCIAL HISTORY

	Yes	No		Yes	No
Ever smoked? Packs/day: ____ # of years: ____ Quit date: _____	☐	☐	Regular exercise? How often? _____	☐	☐
Do you currently smoke? Packs/day: ____ # of years: ____	☐	☐	Dairy product intake/calcium supplements? How much? _____	☐	☐
Do you drink alcohol? # drinks/day: _____ # drinks/week: _____	☐	☐	Health hazards at home or work?	☐	☐
Any recreational drug use?	☐	☐	Have you ever been sexually abused, threatened, or hurt by anyone?	☐	☐
Seat belt use?	☐	☐	Do you want to talk about any sexual concerns?		

PERSONAL PAST HISTORY OF ILLNESSES

Please check any boxes that apply to you and include the date of illness or diagnosis.

Major Illness	Yes (date)	Major Illness	Yes (date)	Major Illness	Yes (date)
Anemia	☐	Depression/anxiety	☐	Lupus	☐
Arthritis/joint pain	☐	Diabetes	☐	Pneumonia/lung disease	☐
Asthma	☐	Eating disorders	☐	Reflux/hiatal hernia/ulcers	☐
Back problems	☐	Gallbladder disease	☐	Rheumatic fever	☐
Blood clots in lungs or legs	☐	Glaucoma	☐	Seizures/convulsions/epilepsy	☐
Blood transfusions	☐	Headaches	☐	Sexually transmitted disease	☐
Bowel problems	☐	Heart attack/heart problems	☐	Stroke	☐
Broken bones	☐	Hepatitis/liver disease	☐	Thyroid disease	☐
Cancer	☐	High blood pressure	☐	Tuberculosis	☐
Cataracts	☐	HIV/AIDS	☐	Other illness	☐
Chicken pox	☐	Kidney infection/stones	☐		☐

SURGERY/HOSPITALIZATIONS

What (type of surgery/reason for hospitalization)	Date	Where (hospital name)

MEDICATIONS/VITAMINS/SUPPLEMENTS

Please use separate sheet of paper if needed.

Name	How much? How often?	What do you take it for?	Date began taking?

INJURIES

Type of injury	Date

FAMILY HISTORY

Mother: Year born: _____ ☐ Alive ☐ Deceased/Age and cause: _____	**Father:** Year born: _____ ☐ Alive ☐ Deceased/Age and cause: _____
Siblings: Number living: ___ Number deceased: ___ Cause(s) of death:	
Children: Number living: ___ Number deceased: ___ Cause(s) of death:	

Illness	Yes	Which relative(s)? Age of onset?	Illness	Yes	Which relative(s)? Age of onset?
Alzheimer's disease	☐		High cholesterol	☐	
Birth defects	☐		HIV/AIDS	☐	
Blood clots in lungs/legs	☐		Mental illness/depression	☐	
Breast cancer	☐		Osteoporosis	☐	
Colon cancer	☐		Ovarian cancer	☐	
Diabetes	☐		Stroke	☐	
Drinking/drug problems	☐		Tuberculosis	☐	
Heart disease	☐		Uterine cancer	☐	
Hepatitis	☐		Other	☐	
High blood pressure	☐			☐	

REVIEW OF SYSTEMS

	Now	Past		Now	Past
1. Constitutional			Incomplete emptying	☐	☐
Weight loss	☐	☐	Involuntary/unintended urine loss	☐	☐
Weight gain	☐	☐	Urine loss when coughing or lifting	☐	☐
Fever	☐	☐	Abnormal bleeding	☐	☐
Fatigue	☐	☐	Painful periods	☐	☐
Change in height	☐	☐	Fibroids	☐	☐
2. Eyes			Infertility	☐	☐
Double vision	☐	☐	DES exposure	☐	☐
Spots before eyes	☐	☐	Abnormal vaginal discharge	☐	☐
Vision changes	☐	☐	**8. Musculoskeletal**		
Glasses/contacts	☐	☐	Muscle weakness	☐	☐
3. Ear, nose, and throat			Muscle or joint pain	☐	☐
Ear aches	☐	☐	**9. Skin**		☐
Ringing in ears	☐	☐	Rash	☐	☐
Hearing problems	☐	☐	Sores	☐	☐
Sinus problems	☐	☐	Dry skin	☐	☐
Sore throat	☐	☐	Moles	☐	☐
Mouth sores	☐	☐	**10. Breasts**		
Dental problems	☐	☐	Pain in breast	☐	☐
4. Cardiovascular			Nipple discharge	☐	☐
Painful breathing	☐	☐	Lumps	☐	☐
Chest pain or pressure	☐	☐	**11. Neurologic**		
Difficulty breathing on exertion	☐	☐	Dizziness	☐	☐
Swelling of legs	☐	☐	Seizures	☐	☐
Rapid or irregular heartbeat	☐	☐	Numbness	☐	☐
5. Respiratory			Trouble walking	☐	☐
Wheezing	☐	☐	Severe memory problems	☐	☐
Spitting up blood	☐	☐	Frequent or severe headaches	☐	☐
Shortness of breath	☐	☐	**12. Psychiatric**		
Chronic cough	☐	☐	Depression or frequent crying	☐	☐
6. Gastrointestinal			Severe anxiety	☐	☐
Frequent diarrhea	☐	☐	**13. Endocrine**		
Bloody stool	☐	☐	Hair loss	☐	☐
Nausea/vomiting/indigestion	☐	☐	Heat/cold intolerance	☐	☐
Constipation	☐	☐	Abnormal thirst	☐	☐
Involuntary loss of gas or stool	☐	☐	Hot flashes	☐	☐
7. Genitourinary			**14. Hematologic/lymphatic**		
Blood in urine	☐	☐	Frequent bruises	☐	☐
Pain with urination	☐	☐	Cuts that do not stop bleeding	☐	☐
Strong urgency to urinate	☐	☐	Enlarged lymph nodes (glands)	☐	☐
Frequent urination	☐	☐		☐	☐