

Specializing in Menopause, Contraceptive/Family Planning, Menstrual Abnormalities,
Comprehensive Women's Health Care and Gynecological Preventive Care

Hours: Tuesday and Thursday, 8:00 am to 4:30 pm

****Please have this form completed PRIOR to your visit. Co-pays are to be paid on the date of service.**

Date: _____

If you are uncomfortable answering any questions, please leave them blank;
you can discuss them with the doctor or nurse.

PATIENT INTAKE HISTORY	
Last name:	First name:
Birthdate: / /	
Primary Doctor:	Referred by:
What is the reason for today's visit?	
Preferred Pharmacy:	
Please describe your problem, including where it is, how severe, and how long it has lasted:	

GYNECOLOGIC HISTORY	
Last normal menstrual period (first day): / /	Age period began:
Length of periods (number of days):	Number of days between periods:
Are you currently sexually active?	Have you ever had sex?
Number of sexual partners (lifetime):	Partners are: <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both
Present method of birth control:	When was your last PAP?
Last Mammogram?	What was the result?
Do you do breast self-examinations?	Have you ever had an abnormal PAP?

OBSTETRIC HISTORY				
	Number		Number	Number
Pregnancies:		Abortions:		Miscarriages
Live Births		Premature Births (weeks?)		Living Children
Any pregnancy complications?				
<input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension/High Blood Pressure <input type="checkbox"/> Preeclampsia/Toxemia <input type="checkbox"/> Other				

SOCIAL HISTORY				
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Long-Term Relationship <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				
Ever Smoked? <input type="checkbox"/> Y <input type="checkbox"/> N	Currently Smoking? <input type="checkbox"/> Y <input type="checkbox"/> N	Packs per day:	For how many years?	
Drug Use? <input type="checkbox"/> Y <input type="checkbox"/> N	If yes, please specify:			
Alcohol? <input type="checkbox"/> Y <input type="checkbox"/> N	Drinks per day:	Drinks per week:		
Regular exercise:		How long and how often?		
Dairy product intake and/or calcium supplements:			Daily intake:	
Have you ever been sexually abused, threatened, or hurt by anyone?			Do you have a living will?	
Number of people in your household?		Highest level of completed schooling?		

PAST HISTORY OF ILLNESSES

Major Illness	Mother	Father	Sister	Brother	Mat Grand Mother	Mat Grand Father	Pat Grand Mother	Pat Grand Father
Alcohol/Drug Problems								
Alzheimer's								
Anemia								
Arthritis/Cont. Pain/Back Problems								
Asthma								
Autoimmune Disease (Lupus)								
Birth defects								
Bleeding Disorders								
Blood Clots in lungs/legs								
Blood Transfusions								
Bowel Problems:								
Cancer (what kind?)								
Depression/Anxiety								
Diabetes								
Eating Disorder								
Eye Problems								
Fibroids								
Gall Bladder Disease								
Headaches								
Heart Attack/Heart Disease								
Hepatitis/Yellow Jaundice/Liver Disease								
High Blood Pressure								
High Cholesterol								
HIV/AIDS								
Infertility								
Kidney Infections/Stones								
Osteoporosis								
Pneumonia/Lung Disease								
Reflux/Hiatal Hernia/Ulcers								
Rheumatic Fever								
Seizures/Convulsions/Epilepsy								
Sexually Transmitted Disease/Chlamydia								
Stroke								
Thyroid Disease								
Tuberculosis								
Other:								

CURRENT MEDICATIONS

(Please include any over the counter medications and vitamins.)

Drug name	Dosage	Who Prescribed

Any Medication or Latex Allergies? If so, to what?

OPERATIONS/HOSPITALIZATIONS

Reason	Date	Hospital

REVIEW OF SYMPTOMS

	Now	Past	Explain
CONSTITUTIONAL:	<input type="checkbox"/>	<input type="checkbox"/>	
Weight loss/gain; Fever; Fatigue; Change in height	<input type="checkbox"/>	<input type="checkbox"/>	
GASTROINTESTINAL:			
Frequent diarrhea; bloody stool; constipation	<input type="checkbox"/>	<input type="checkbox"/>	
nausea/vomiting/indigestion; involuntary loss of gas/stool	<input type="checkbox"/>	<input type="checkbox"/>	
GENITOURINARY:			
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	
Painful urination	<input type="checkbox"/>	<input type="checkbox"/>	
Strong urgency to urinate/frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	
Incomplete emptying	<input type="checkbox"/>	<input type="checkbox"/>	
Involuntary/unintended urine loss	<input type="checkbox"/>	<input type="checkbox"/>	
Urine loss when lifting/coughing	<input type="checkbox"/>	<input type="checkbox"/>	
Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	
Painful periods	<input type="checkbox"/>	<input type="checkbox"/>	
Premenstrual syndrome (PMS)	<input type="checkbox"/>	<input type="checkbox"/>	
Painful intercourse	<input type="checkbox"/>	<input type="checkbox"/>	
Abnormal Vaginal Discharge	<input type="checkbox"/>	<input type="checkbox"/>	
SKIN:			
Rash; Sores; Dry Skin; Moles (growth/change)	<input type="checkbox"/>	<input type="checkbox"/>	
BREASTS:			
Pain in Breast; Nipple Discharge; Lumps	<input type="checkbox"/>	<input type="checkbox"/>	
PSYCHIATRIC:			
Depression/frequent crying; anxiety	<input type="checkbox"/>	<input type="checkbox"/>	
ENDOCRINE:			
Hair loss; heat/cold intolerance; hot flashes; abnormal thirst	<input type="checkbox"/>	<input type="checkbox"/>	

Form completed by: Patient Office Nurse Physician Other _____

Signature of Patient: _____ **Date:** _____