Patient Intake Form

Date: __/____/____ Patient name: _____DOB:_____

Reason for today's visit: _____

Gynecological History

Are you still having menstrual periods? □ Yes □ If no age you stopped_____

First day of last menstrual period: _____How old were you when your menses started?_____

If so, periods are: □ Light □ Moderate □ Heavy □ Bleed through protection

How many days between your periods? _____ How many days of menstrual flow? _____

Do you have any pain with your periods? □ Yes □ No Do you have bleeding in-between periods? □ Yes □ No

Do you have bleeding after intercourse? □ Yes □ No Have you ever had a blood transfusion? □ Yes □ No

Have you ever been diagnosed with fibroids? □ Yes □ No Are you suffering from PMS? □ Yes □ No

Are you sexually active? □ Yes □ No

If so, with: □ one partner □ multiple partners If so, with: □ Male □ Female □ Both

What is your present method of birth control? _____

Date of last Pap Smear: _____ Result: _____

Have you ever had an abnormal Pap or Colposcopy? □Yes □No

Have you had any treatments to your cervix? □ Cryosurgery □ Laser Surgery □ LEEP □ Conization □ Other

Have you ever had a sexually transmitted infection?

□ No □ Chlamydia □ Gonorrhea □ Herpes □ Syphilis □ HIV □ Trichomonas

Past Pregnancies

Date of delivery	Outcome	Hospital	Complications

Past Operations

□ Hysterectomy □D&C □ Ceasarean □ Tubal Ligation Gallbladder Appendix

Other:_____

_____

Medical History

Diabetes Hypertension Thyroid disorder Osteoporosis Arthritis Reflux

Other:_____

Allergies to Medications

(please list medication and what type of reaction you had):

_____

_____

Current Medications:

(please list all medicine and dosing including over the counter medications)

_____

_____

Social History

Circle one SINGLE MARRIED DIVORCED WIDOWED

Occupation:_____

Current and Past Alcohol Intake (drinks per week): _____

Have you ever received treatment for substance abuse? □ Yes □ No

If you smoke: number of Cigarettes Per Day: _____

Have you smoked in the past? □ Yes □ No

Past Cigarette Use (years): _____

Personal Safety

Do you feel safe in your current relationship? □ Yes □ No

Have you ever been sexually, physically or emotionally abused? □ Yes □ No

Do you wear a seatbelt? □ Yes □ No

Health Maintenance and Screening:

Date and result of last mammogram: Date: _____ Result: _____

Have you ever had an abnormal mammogram, breast ultrasound or breast biopsy? □ Yes □ No

Do you do self breast exams? □ Yes □ No

Date and result of last colonoscopy or sigmoidoscopy (50 +): Date: _____ Result: _____

Date and result of last bone density test: Date: _____ Result: _____

Date of last HPV vaccine: Date: _____

If you had, did you receive all three shots? □ Yes □ No

Date of last tetanus vaccine: Date: _____

Date of last influenza vaccine: Date: _____

Date of last pneumococcal vaccine: Date: _____

Date of last shingles vaccine: Date: _____

Do you have another primary care provider (family doctor, internist, nurse practitioner) who is taking care of you for regular check-ups? □ Yes □ No

If yes, please provide name and contact number: _____

Family History

Parents, Grandparents, Siblings, Children – Please indicate the person(s)

□ Breast Cancer _____ □ Diabetes _____ □ Osteoporosis _____

□ Ovarian Cancer _____ □ High Cholesterol _____ Mental Retardation_____

□ Uterine Cancer _____ □ High Blood Pressure _____ Congenital Birth Defects_____

□ Colon Cancer _____ □ Heart Disease _____