PATIENT INTAKE HISTORY

PATIENT NAME:	BIRTHDATE:	TODAYS DATE:
ADDRESS:		
CITY	STATE/ZIP:	
HOME PHONE: ( )	CELL PHONE: ( )	
PATIENT EMAIL ADDRESS:	INSURANCE:	POLICY #:
EMPLOYER:	REFERRED BY:	
NAME YOU WOULD LIKE TO USE:	EMERGENCY CONTACT:	
NAME OF SPOUSE/PARTNER:	RELATIONSHIP:	
SPOUSE/PARTNER'S DOB:	PARTNER'S CELL PHONE: ( )	
PARTNE'S HOME PHONE: ( )	PRIMARY LANGUAGE:	
PARTNER'S EMAIL	REASON FOR THE APPOINTMENT: □ ANNUAL EXAM □ GYN ISSUES □ INFERTILITY □ OTHER _____	
IS THIS A NEW PROBLEM:		
PLEASE DESCRIBE YOUR PROBLEM, INCLUDE WHERE IT IS AND HOW LONG IT HAS LASTED:		

PLEASE COMPLETE THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE. IF YOU ARE UNCOMFORTABLE ANSWERING ANY QUESTIONS, LEAVE THEM BLANK; YOU CAN DISCUSS THEM WITH YOUR DOCTOR OR NURSE.

GYNECOLOGIC HISTORY

	PHYSICIAN'S NOTES
LAST NORMAL MENSTURAL PERIOD (FIRST DAY): / /	
AGE PERIODS BEGAN:	
LENGTH OF PERIODS (NUMBER OF DAYS OF BLEEDING):	
NUMBER OF DAYS BETWEEN PERIODS:	
ANY RECENT CHANGES IN PERIOD?	
ARE YOU CURRENTLY SEXUALLY ACTIVE?	
HAVE YOU EVER HAD SEX	
NUMBER OF SEXUAL PARTNERS (LIFETIME):	
SEXUAL PARTNERS ARE: □ MEN □ WOMEN □ BOTH	
PRESENT METHOD OF BIRTJH CONTROL:	
HAVE YOU EVER USED AN INTRAUTERINE DEVICE (IUD) OR BIRTH CONTROL PILLS:	
IF YES, FOR HOW LONG:	
WHEN WAS YOUR LAST PAP TEST?	
WHAT WAS THE RESULT?	
HAVE YOU EVER HAD AN ABNORMAL PAP TEST?	
DO YOU DO BREAST SELF-EXAMINATION?	
HAVE YOU BEEN EXPOSED TO DIETHYLSTILBESTROL (DES)?	

PATIENT INTAKE HISTORY

PATIENT NAME:	BIRTH DATE:	ID NO:	DATE:

OBSTETRIC HISTORY

	NUMBER		NUMBER		NUMBER
PREGNANCIES		ABORTIONS		MISCARRIAGES	
PREMATURE BIRTH (<37WKS)		LIVE BIRTHS		LIVING CHILDREN	

NO.	BIRTH DATE	BABY'S SEX	WEEKS PREGNANT	TYPE OF DELIVERY (VAGINAL, CESAREAN, ETC.	PHYSICIANS NOTES
1.					
2.					
3.					
4.					

ANY PREGNANCY COMPLICATINS?

□ DIABETES □ HYPERTENSION/HIGH BLOOD PRESSURE □ PRECLAMPSIA/TOXEMIA □ OTHER

ANY HISTORY OF DEPRESSION BEFOR OR AFTER PREGNANCY? □ NO □ YES, HOW TREATED

CURRENT MEDICATIONS

(INCLUDING HORMONES, VITAMINS, HERBS, NONPRESCRIPTION MEDICATIONS)

DRUG NAME	DOSAGE	WHO PRESCRIBED	DRUG NAME	DOSAGE	WHO PRESCRIBED

FAMILY HISTORY

MOTHER: □ LIVING □ DECEASED-CAUSE	AGE:	FATHER □ LIVING □ DECEASED-CAUSE:	AGE:
SIBLINGS: NUMBER LIVING:	NUMBER DECEASED:	CAUSE(S)/AGE(S):	
CHILDREN: NUMBER LIVING:	NUMBER DECEASED:	CAUSE(S)/AGE(S):	

ILLNESS	YES	NO	WHICH RELATIVE(S) & AGE OF ONSET	PHYSICIAN'S NOTES
DIABETES	□	□		
STROKE	□	□		
HEART DISEASE	□	□		
BLOOD CLOT IN LUNGS OR LEGS	□	□		
HIGH BLOOD PRESSURE	□	□		
HIGH CHOLESTEROL	□	□		
OSTEOPOROSIS(WEAK BONES)	□	□		
HEPATITIS	□	□		
HIV/AIDS	□	□		
TUBERCULOSIS	□	□		
BIRTH DEFECTS	□	□		
ALCOHOL OR DRUG PROBLEMS	□	□		
BREAST CANCER	□	□		
COLON CANCER	□	□		
OVARIAN CANCER	□	□		
UTERINE CANCER	□	□		
MENTAL ILLNESS/DEPRESSION	□	□		
ALZHEIMER'S DISEASE	□	□		
OTHER	□	□		

PATIENT INTAKE HISTORY

PATIENT NAME:	BIRTH DATE:	ID NO:	DATE: / /

SOCIAL HISTORY

	YES	NO	PHYSICIAN'S NOTES
EVER SMOKED? CURRENT SMOKING: PACKS PER DAY: YEARS:	□	□	
ALCOHOL: DRINKS/DAY: DRINKS/WEEK TYPE OF DRINK	□	□	
DRUG USE:	□	□	
SEAT BELT USE:	□	□	
REGULAR EXERCISE: HOW LONG AND HOW OFTEN?	□	□	
DAIRY PRODUCTS INTAKE AND/OR CALCIUM SUPPLEMENTS: DAILY INTAKE:	□	□	
HEALTH HAZARDS AT HOME OR WORK?	□	□	
HAVE YOU BEEN SEXUALLY ABUSED, THREATENED OR HURT BY ANYONE?	□	□	
DO YOU HAVE AN ADVANCE DIRECTIVE (LIVING WILL)?	□	□	
ARE YOU AN ORGAN DONOR?	□	□	

PERSONAL PROFILE

SEXUAL ORIENTATION: □ HETEROSEXUAL □ HOMOSEXUAL □ BISEXUAL	
MARITAL STATUS: □ MARRIED □ LIVING WITH PARTNER □ SINGLE □ WIDOWED □ DIVORCED	
NUMBER OF LIVING CHILDREN	NUMBER OF PEOPLE IN HOUSEHOLD
SCHOOL COMPLETED: □ HIGH SCHOOL □ SOME COLLEGE/AA DEGREE □ COLLEGE □ GRADUATE SCHOOL □ OTHER	
CURRENT OR MOST RECENT JOB	
HAVE YOU TRAVELED OUTSIDE OF UNITED STATES? WHEN? LOCATION(S)	

PERSONAL PAST HISTORY OF ILLNESSES

MAJOR ILLNESSES	YES (DATE)	NO	PHYSICIANS'S NOTES
ASTHMA			
PNEUMONIA/LUNG DISEASE			
KIDNEY INFECTION/STONES			
TUBERCULOSIS			
FIBROIDS			
SEXUALITY TRANSMITTED DISEASE/CHLAMYDIA			
INFERTILITY			
HIV/AIDS			
HEART ATTACK/DISEASE			
DIABETES			
HIGH BLOOD PRESSURE			
STROKE			
RHEUMATIC FEVER			
BLOOD CLOTS IN LUNGS OR LEGS			
EATING DISORDERS			
AUTOIMMUNE DISEASE (LUPUS)			
CHICKENPOX			
CANCER			
REFLUX/HIATAL HERNIA/ULCER			
DEPRESSION ANXIETY			
ANEMIA			
BLOOD TRANSFUSIONS			
SEIZURES/CONVULSIONS/EPILEPSY			
BOWEL PROBLEMS			
GLAUCOMA			
CATARACTS			

PATIENT INTAKE HISTORY

PATIENT NAME:	BIRTH DATE:	ID NO:	DATE: / /

PERSONAL PAST HISTORY OF ILLNESSES (CONTINUED)

MAJOR ILLNESSES	YES (DATE)	NO	PHYSICIANS'S NOTES
ARTHRITIS/JOINT PAIN/BACK PROBLEM			
BROKEN BONES			
HEPATITIS/YELLOW JAUNDICE/LIVER DISEASE			
THYRIOD DISEASE			
GALLBLADDER DISEASE			
HEADACHE			
DES EXPOSURE			
BLEEDING DISORDERS			
OTHER			

SEXUAL HISTORY

AGE OF YOUR PARTNER?	PARTNER'S OCCUPATION
WHEN WAS THE LAST TIME YOU ENGAGED IN INSEXUAL INTERCOURSE?	
DO YOU LIVE WITH YOUR SEXUAL PARTNER?	HOW OFTEN DO YOU HAVE SEXUAL INTERCOURSE?
DO YOU OR YOUR PARTNER HAVE PROBLEMS WITH SEXUAL FUNCTIONS?	
DOES YOUR PARTNER HAVE ANY CHILDREN OR HAS HE EVER HAD ANYONE CONCEIVE WITH HIM?	
DOES YOUR PARTNER HAVE DIFFICULTY WITH EJACULATION?	
DOES YOUR PARTNER HAVE ANY BROTHERS WHO HAVE CHILDREN?	
DOES YOUR PARTNER HAVE ANY HISTORY OF GENETIC DISEASES IN HIS FAMILY?	
HAS YOUR PARTNER EVER HAD SURGERY ON HIS TESTES FOR VERICOCELE BEFORE?	
IS YOUR PARTNER EXPOSED TO ANY CHEMICALS TOXINS AT WORK OR AT HOME?	
DOES YOUR PARTNER USE SAUNAS OR LIGHT TO SOAK IN HOT TUBS	
IS YOUR PARTNER ON ANY MEDICATIONS?	
DOES YOU PARTNER HAVE DIABETES □ YES □ NO	DOES YOUR PARTNER HAVE HIGH BLOOD PRESSURE? □ YES □ NO
WAS YOUR PARTNER TREATED FOR MUMPS AS A CHILD? □ YES □ NO	
IS THER ANYTHING ELSE THAT I NEED TO KNOW ABOUT YOUR SEXUALITY IN ORDER TO PROVIDE YOU WITH GOOD MEDICAL CARE? EXPLAIN.	

OPERATIONS/HOSPITALIZATIONS

REASON	DATE	HOSPITAL

INJURY/ ILLNESSES

TYPE	DATE	TYPE	DATE

IMMUNIZATIONS/TEST

	DATE		DATE
TETANUS-DIPHTHERIA BOSTER		INFLUENZA VACCINE (FLU SHOT)	
HEPATITIS A VACCINE		HEPATITIS B VACCINE	
VARICELLA (CHICKENPOX) VACCINE		PNEUMOCOCCAL (PNEUMONIA) VACCINE	
MEASLES-MUMPS-RUBELLA (MMR) VACCINE		TUBERCULOSIS (TB) SKIN TEST RESULT:	

PHYSICIAN'S NOTES:

PATIENT INTAKE HISTORY

PATIENT NAME:	BIRTH DATE:	ID NO:	DATE: / /

REVIES OF SYMPTOMS

Please check (x) if any of the following symptoms apply to you now or since adulthood

	NOW	PAST	NOT SURE	PHYSICIAN'S NOTES
1. CONSTITUTIONAL				
WEIGHT LOSS	□	□	□	
WEIGHT GAIN	□	□	□	
FEVER	□	□	□	
FATIGUE	□	□	□	
CHANGE IN HEIGHT	□	□	□	
2. EYES				
DOUBLE VISION	□	□	□	
SPOTS BEFORE EYES	□	□	□	
VISION CHANGES	□	□	□	
GLASSES/CONTACTS	□	□	□	
3. EAR, NOSE AND THROAT				
EARACHES	□	□	□	
RINGING IN EARS	□	□	□	
HEARING PROBLEMS	□	□	□	
SINUS PROBLEMS	□	□	□	
SORE THROAT	□	□	□	
MOUTH SORES	□	□	□	
DENTAL PROBLEM	□	□	□	
4. CARDIOVASCULAR				
CHEST PAIN OR PRESSURE	□	□	□	
DIFFICULT BREATHING ON EXERTION	□	□	□	
SWELLING OF LEGS	□	□	□	
RAPID OR IRREGULAR HEARTBEAT	□	□	□	
5. RESPIRATORY				
PAINFUL BREATHING	□	□	□	
WHEEZING	□	□	□	
SPITTING UP BLOOD	□	□	□	
SHORTNESS OF BREATH	□	□	□	
CHRONIC CAUGH	□	□	□	
6. GASTROINTESTINAL				
FREQUENT DIARRHEA	□	□	□	
BLOODY STOOL	□	□	□	
NAUSEA/VOMITING/INDEGESTION	□	□	□	
CONSTIPATION	□	□	□	
INVOLUNTARY LOSS OF GAS OR STOOL	□	□	□	
7. GENITOURINARY				
BLOOD IN URINE	□	□	□	
PAIN WITH URINATION	□	□	□	
STRONG URGENCY TO URINATE	□	□	□	
FREQUENT URINATION	□	□	□	
INCOMPLETE EMPTYING	□	□	□	
INVOLUNTARY/UNINTEDED URINE LOSS	□	□	□	
URINE LOSS WHEN COUGING OR LIFTING	□	□	□	
ABNORMAL BLEEDING	□	□	□	
PAINFUL PERIODS	□	□	□	
PREMENSTURAL SYNDROME (PMS)	□	□	□	
PAINFUL INTERCOURSE	□	□	□	
ABNORMAL VAGINAL DISCHARGE	□	□	□	

PATIENT INTAKE HISTORY

PATIENT NAME:	BIRTH DATE:	ID NO:	DATE: / /

REVIES OF SYMPTOMS (CONTINUED)

Please check (x) if any of the following symptoms apply to you now or since adulthood

8. MUSCULOSKELETAL				
MUSCLE WHEAKNESS	□	□	□	
MUSCLE OR JOINT PAIN	□	□	□	
9. SKIN				
RASH	□	□	□	
SORES	□	□	□	
DRY SKIN	□	□	□	
MOLES (GROWTH OR CHANGES)	□	□	□	
10. BREAST				
PAIN IN BREAST	□	□	□	
NIPPLE DISCHARGE	□	□	□	
LUMPS	□	□	□	
11. NEUROLOGIC				
DIZZINESS	□	□	□	
SEIZURES	□	□	□	
NUMBNESS	□	□	□	
TROUBLE WALKING	□	□	□	
MEMORY PROBLEMS	□	□	□	
FREQUENT HEADACHES	□	□	□	
12. PSYCHIATRIC				
DEPRESSION	□	□	□	
ANXIETY	□	□	□	
13. ENDOCRINE				
HAIR LOSS	□	□	□	
HEAT/COLD INTOLERANCE	□	□	□	
ABNORMAL THIRST	□	□	□	
HOT FLASHES	□	□	□	
14. HEMATOLOGIC/LYMPHATIC				
FREQUENT BRUISES	□	□	□	
CUTS DO NOT STOP BLEEDING	□	□	□	
ENLARGED LYMPH NODES (GLANDS)	□	□	□	
15. ALLERGIC/IMMUNOLOGIC				
MEDICATION ALLERGIES	□	□	□	
IF ANY, PLEASE LIST ALLERGY AND TYPE OF REACTION:				
LATEX ALLERGY	□	□	□	
OTHER ALLERGIES	□	□	□	
PLEASE LIST ALLERGY AND TYPE OF REACTION:				
FORM COMPLETED BY: □ PATIENT □ OFFICE NURSE □ PHYSICIAN □ OTHER:				
SIGNATURE OF PATIENT:				
DATE REVIEWED BY PHYSICIAN WITH PATIENT: / /				PHYSICIAN SIGNATURE:
ANNUAL REVIEW OF HISTORY				
DATE REVIEWED: / /				PHYSICIAN SIGNATURE:
DATE REVIEWED: / /				PHYSICIAN SIGNATURE: