☐ ESTABLISHED PATIENT
☐ CONSULTATION
☐ REPORT SENT: / /

PATIENT INTAKE HISTORY

PATIENT NAME:	BIRTH DATE: / /	ID NO.:	DATE: / /
ADDRESS:			
CITY:	STATE/ZIP:		
HOME TELEPHONE: ( )	WORK TELEPHONE: ( )		
EMPLOYER:	INSURANCE:		
NAME YOU WOULD LIKE US TO USE:			
NAME OF SPOUSE/PARTNER:	EMERGENCY CONTACT:		
	RELATIONSHIP:		
	HOME TELEPHONE: ( )	WORK TELEPHONE: ( )	
REFERRED BY:			
WHY HAVE YOU COME TO THE OFFICE TODAY?			
IF YOU ARE HERE FOR AN ANNUAL EXAMINATION IS THIS A ☐ PRIMARY CARE VISIT OR ☐ GYNECOLOGY ONLY			
IS THIS A NEW PROBLEM?			
PLEASE DESCRIBE YOUR PROBLEM, INCLUDING WHERE IT IS, HOW SEVERE IT IS, AND HOW LONG IT'S LASTED.			

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 MENSTRUAL PERIOD (FIRST DAY): / /	
AGE PERIODS BEGAN:	
LENGTH OF PERIODS (NUMBER OF DAYS OF BLEEDING):	
NUMBER OF DAYS BETWEEN PERIODS:	
ANY RECENT CHANGES IN PERIODS?	
ARE YOU CURRENTLY SEXUALLY ACTIVE?	
HAVE YOU EVER HAD SEX?	
NUMBER OF SEXUAL PARTNERS (LIFETIME):	
SEXUAL PARTNERS ARE ☐ MEN ☐ WOMEN ☐ BOTH	
PRESENT METHOD OF BIRTH 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 REGULAR BREAST SELF-EXAMINATIONS?	

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PATIENT INTAKE HISTORY *(Continued)*

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

OBSTETRIC HISTORY

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

NO.	BIRTH DATE	WEIGHT AT BIRTH	BABY'S SEX	WEEKS PREGNANT	TYPE OF DELIVERY (VAGINAL, CESAREAN, ETC.)	COMPLICATIONS?
1.						
2.						
3.						
4.						

PHYSICIAN'S NOTES ON OBSTETRIC HISTORY:

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	WHICH RELATIVE(S) AND AGE OF ONSET	PHYSICIAN'S NOTES
DIABETES	☐		
STROKE	☐		
HEART DISEASE	☐		
BLOOD CLOTS IN LUNGS OR LEGS	☐		
HIGH BLOOD PRESSURE	☐		
HIGH CHOLESTEROL	☐		
OSTEOPOROSIS (WEAK BONES)	☐		
HEPATITIS	☐		
HIV/AIDS	☐		
TUBERCULOSIS	☐		
BIRTH DEFECTS	☐		
DRINKING OR DRUG PROBLEMS	☐		
BREAST CANCER	☐		
COLON CANCER	☐		
OVARIAN CANCER	☐		
UTERINE CANCER	☐		
MENTAL ILLNESS/DEPRESSION	☐		
ALZHEIMER'S DISEASE	☐		
OTHER	☐		

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

SOCIAL HISTORY

	YES	NO	PHYSICIAN'S NOTES
EVER SMOKED? CURRENT SMOKING: PACKS PER DAY: YEARS:	☐	☐	
ALCOHOL: DRINKS PER DAY: DRINKS PER WEEK:	☐	☐	
RECREATIONAL DRUG USE	☐	☐	
SEAT BELT USE	☐	☐	
REGULAR EXERCISE: HOW LONG AND HOW OFTEN?	☐	☐	
DAIRY PRODUCT INTAKE/CALCIUM SUPPLEMENTS: QUANTITY	☐	☐	
HEALTH HAZARDS AT HOME OR WORK?	☐	☐	
HAVE YOU BEEN SEXUALLY ABUSED, THREATENED, OR HURT BY ANYONE?	☐	☐	

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 DEGREE ☐ OTHER

CURRENT OR MOST RECENT JOB:

TRAVEL OUTSIDE THE U.S.? LOCATION:

PERSONAL PAST HISTORY OF ILLNESSES

MAJOR ILLNESSES	YES (DATE)	NO	NOT SURE	PHYSICIAN'S NOTES
ASTHMA				
PNEUMONIA/LUNG DISEASE				
KIDNEY INFECTIONS/STONES				
TUBERCULOSIS				
SEXUALLY TRANSMITTED DISEASE				
HIV/AIDS				
HEART ATTACK/PROBLEMS				
DIABETES				
HIGH BLOOD PRESSURE				
STROKE				
RHEUMATIC FEVER				
BLOOD CLOTS IN LUNGS OR LEGS				
EATING DISORDERS				
COLLAGEN VASCULAR DISEASE (LUPUS)				
CHICKENPOX				
CANCER				
REFLUX/HIATAL HERNIA/ULCERS				
DEPRESSION/ANXIETY				
ANEMIA				
BLOOD TRANSFUSIONS				
SEIZURES/CONVULSIONS/EPILEPSY				
BOWEL PROBLEMS				
GLAUCOMA				
CATARACTS				
ARTHRITIS/JOINT PAIN/BACK PROBLEMS				
BROKEN BONES				
HEPATITIS/YELLOW JAUNDICE/LIVER DISEASE				
THYROID DISEASE				

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

PERSONAL PAST HISTORY OF ILLNESSES *(Continued)*

MAJOR ILLNESSES	YES (DATE)	NO	NOT SURE	PHYSICIAN'S NOTES
GALLBLADDER DISEASE				
HEADACHES				
OTHER				

OPERATIONS/HOSPITALIZATIONS

REASON	DATE	HOSPITAL

INJURIES/ILLNESSES

TYPE	DATE	TYPE	DATE

IMMUNIZATIONS/TEST

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

PHYSICIAN'S NOTES:

REVIEW OF SYSTEMS

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	☐	☐	☐	

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