GYNECOLOGIC INTAKE HISTORY

Name: _____ Birth Date _____/_____/_____ Date _____/_____/_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____

Employer: _____ Insurance: _____

Name of Spouse/Partner: _____ Referred By: _____

Family Doctor: _____

PAST MEDICAL HISTORY					
MAJOR ILLNESSES	YES	NO		YES	NO
Asthma			Cancer		
Pneumonia			Ulcers		
Chronic Lung Disease			Depression/anxiety		
Kidney Infections/Stones			Blood Transfusion		
High Cholesterol			Seizure/convulsions/epilepsy		
Heart Attack			Bowel trouble		
Diabetes			Glaucoma		
High Blood Pressure			Arthritis/Joint pain		
Stroke			Fracture		
DVT/PE			Hepatitis		
Heart Murmur			Thyroid Disease		

SURGICAL PROCEDURES			
Reason	Date	Reason	Date

HOSPITALIZATIONS			
Type	Date	Type	Date

LAST IMMUNIZATION OR TEST			
	Date		Date
Gardasil		Varivax	
Tetanus		Pneumonia	
Flu shot		TB Skin Test	

OB/GYN HISTORY			
	Number		Number
Births		Abortions	
Miscarriages		Living Children	

CURRENT MEDICATIONS			
Drug Name	Dosage	Drug Name	Dosage

FAMILY HISTORY					
Illness	Yes	Relative	Illness	Yes	Relative
Diabetes			High Cholesterol		
Stroke			Breast Cancer		
Heart Disease			Colon Cancer		
High Blood Pressure			Ovarian Cancer		
DVT			Birth Defects		

HABITS	YES	NO				
Smoking			Packs per day		Years	
Alcohol			Drinks per day		Drinks per week	
Drug Use						
Seat Belt Use						
Regular Exercise						

PERSONAL PROFILE				
Marital Status	Married ☐	Single ☐	Widowed ☐	Divorced ☐
Number of Living Children				
Number of People in Household		Sexual Orientation:		
School Completed	High School ☐	College ☐	Graduate Degree ☐	Other ☐
Current or most recent job _____				

PERSONAL SAFETY		
YES	NO	
		Has anyone close to you ever threatened to hurt you?
		Has anyone ever hit, kicked, choked, or hurt you physically?
		Has anyone, including your partner, ever forced you to have sex?
		Are you ever afraid of your partner?

MEDICARE "HIGH RISK" CRITERIA

Have you ever been treated for any of these infections?

Vaginosis	Genital Warts	Chlamydia	Herpes	Trichomonas	Gonorrhea	Syphilis
☐	☐	☐	☐	☐	☐	☐

	YES	NO	
Have you had a Pap smear in the last 7 years?			
Have you ever had an abnormal Pap smear test?			When?
Did you begin sexual activity before you were 16 years old?			
Have you had more than 5 sexual partners in you lifetime?			
Have you ever tested positive for the HIV virus?			
Did your mother take the drug DES while pregnant with you?			

Colonoscopy Date	DEXA Scan Date
Hysterectomy Yes ☐ No ☐	Ovaries Removes Yes ☐ No ☐

Completed by: Patient ☐ Office Nurse ☐ Physician ☐

Signature of Patient: _____

Date reviewed by physician with patient: _____

Physician Signature: _____

Annual Review of History

Date Reviewed: _____ Physician Signature: _____

Date Reviewed: _____ Physician Signature: _____

Date Reviewed: _____ Physician Signature: _____

Date Reviewed: _____ Physician Signature: _____

NAME: _____ Date of office visit _____

ANNUAL SYSTEM REVIEW

(Please check if any of the following apply now and **explain**)

Genitourinary:

Burning or pain with urination
- ☐ Yes
- ☐ No

Pain with Intercourse
- ☐ Yes
- ☐ No

Pelvic Pain
- ☐ Yes
- ☐ No

Bleeding with Intercourse
- ☐ Yes
- ☐ No

Heavy Bleeding
- ☐ Yes
- ☐ No

Intermentrual bleeding-irregular bleeding
- ☐ Yes
- ☐ No

Genital Sores
- ☐ Yes
- ☐ No

Contraception
- ☐ Yes
- ☐ No

Vaginal Discharge
- ☐ Yes
- ☐ No

History of colonoscopy and date of procedure
- ☐ Yes
- ☐ No

Vaginal Dryness
- ☐ Yes
- ☐ No

History of chicken pox or date of vaccine
- ☐ Yes
- ☐ No

Painful Periods
- ☐ Yes
- ☐ No

Tetanus vaccination and date of vaccine
- ☐ Yes
- ☐ No

New Sex Partner
- ☐ Yes
- ☐ No

Constitutional:

Weight gain/loss
- ☐ Yes
- ☐ No

Cardiovascular:

Heart trouble
- ☐ Yes
- ☐ No

Respiratory:

Wheezing
- ☐ Yes
- ☐ No

Gastrointestinal:

Bowel changes
- ☐ Yes
- ☐ No

Musculoskeletal:

Muscle weakness
- ☐ Yes
- ☐ No

Skin/Breast:

Breast Lump
- ☐ Yes
- ☐ No

Neurological:

Seizures
- ☐ Yes
- ☐ No

Endocrine:

Hot Flashes
- ☐ Yes
- ☐ No

Hematologic:

Anemia
- ☐ Yes
- ☐ No

Primary Care Physician:

Additional Comments: