

## 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 <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>
Number of Living Children	
Number of People in Household	Sexual Orientation:
School Completed	High School <input type="checkbox"/> College <input type="checkbox"/> Graduate Degree <input type="checkbox"/> Other <input type="checkbox"/>
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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a Pap smear in the last 7 years?				YES	NO	
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	<input type="checkbox"/>	No	<input type="checkbox"/>	Ovaries Removes	Yes <input type="checkbox"/> No <input type="checkbox"/>
Completed by:                      Patient <input type="checkbox"/> Office Nurse <input type="checkbox"/> Physician <input type="checkbox"/>						

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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain with Intercourse <input type="checkbox"/> Yes <input type="checkbox"/> No
Pelvic Pain <input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding with Intercourse <input type="checkbox"/> Yes <input type="checkbox"/> No
Heavy Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No	Intermenstrual bleeding-irregular bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No
Genital Sores <input type="checkbox"/> Yes <input type="checkbox"/> No	Contraception <input type="checkbox"/> Yes <input type="checkbox"/> No
Vaginal Discharge <input type="checkbox"/> Yes <input type="checkbox"/> No	History of colonoscopy and date of procedure <input type="checkbox"/> Yes <input type="checkbox"/> No
Vaginal Dryness <input type="checkbox"/> Yes <input type="checkbox"/> No	History of chicken pox or date of vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No
Painful Periods <input type="checkbox"/> Yes <input type="checkbox"/> No	Tetanus vaccination and date of vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No
New Sex Partner <input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>Constitutional:</b> Weight gain/loss <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Cardiovascular:</b> Heart trouble <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Respiratory:</b> Wheezing <input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>Gastrointestinal:</b> Bowel changes <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Musculoskeletal:</b> Muscle weakness <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Skin/Breast:</b> Breast Lump <input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>Neurological:</b> Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Endocrine:</b> Hot Flashes <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Hematologic:</b> Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No
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**Primary Care Physician:**  
\_\_\_\_\_

**Additional Comments:**  
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