GYNECOLOGIC INTAKE HISTORY

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

Name of Spouse/Partner: _____ Referred By: _____

Family Doctor: _____ Specialist: _____

PAST MEDICAL HISTORY

MAJOR ILLNESSES	YES	NO
Asthma		
Pneumonia		
Chronic Lung Disease		
Kidney Infections/Stones		
High Cholesterol		
Heart Attack		
Diabetes		
High Blood Pressure		
Stroke		
DVT/PE		
Heart Murmur		
MRSA		

	YES	NO
Cancer		
Ulcers		
Depression/anxiety		
Anemia		
Seizure/convulsions/epilepsy		
Blood Transfusion		
Bowel trouble		
Arthritis/Joint pain		
Fracture		
Hepatitis/Fatty liver		
Thyroid Disease		
Migraine		

SURGICAL PROCEDURES

Procedure	Surgeon	Reason	Date

HOSPITALIZATIONS

Type	Date	Type	Date

LAST IMMUNIZATION OR TEST

	Date		Date
Gardasil/HPV		Varivax/Chicken Pox	
Tetanus		Pneumonia	
Flu shot		COVID Vaccine	
		COVID Test Positive?	

OB/GYN HISTORY

	Number		Number
Births		Abortions	
Miscarriages		Living Children	

CURRENT MEDICATIONS

Drug Name	Dosage	Drug Name	Dosage

FAMILY HISTORY - BE SPECIFIC OF WHICH RELATIVE

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?			
Are you sexually active?			

Current Birth control/contraception _____

Contraception used in past? _____

Fibroids? YES ☐ NO ☐

Endometriosis? YES ☐ NO ☐

GYN CONCERNS: _____

Colonoscopy | DEXA Scan Date

Hysterectomy Yes ☐ No ☐ | Ovaries Removed Yes ☐ No ☐

Completed by: Patient ☐ Office Nurse ☐ Physician ☐

Signature of Patient: _____

Date reviewed by physician with patient: _____

Physician Signature: _____