GYNECOLOGY INTAKE FORM

DATE: _____/_____/_____ **AGE:** _____

NAME: _____ **BIRTH DATE:** _____/_____/_____

ADDRESS:_____
CITY **STATE/ZIP**

HOME #: _____ **CELL #:** _____ **WORK #:** _____

PRIMARY CARE MD: _____

An advance directive is a document that indicates your medical care wishes if you are unable to make medical decisions (ie. Coma). Would you like to fill out an advanced directive? ☐ No ☐ Yes

Anything you want to talk to your physician about:

_____

_____

_____

ALLERGIES

MEDICATIONS

DRUG NAMES	DOSAGE	DRUG NAMES	DOSAGE

GYN HISTORY

Menstrual History
What is the first day of your last menstrual period? _____ **How long does it last?** _____
How many days apart are your menstrual cycles starting from the first day of one cycle to the first day of your next cycle?_____
What age did you start having menses? _____

When was your last PAP smear? _____
Have you ever had an abnormal Pap smear? ☐ No ☐ Yes When? _____

What abnormality? _____

Have you ever been treated for: ☐ **Chlamydia** ☐ **Gonorrhea** ☐ **Genital Warts** ☐ **Herpes** ☐ **Trichomonas** ☐ **Syphilis**

Have you ever tested positive for HIV? ☐ No ☐ Yes
Did you mother take the drug DES when she was pregnant with you? ☐ No ☐ Yes

Are you currently sexually active? ☐ No ☐ Yes ☐ Never

Did you begin sexual activity before 16yo? ☐ No ☐ Yes **If yes, Age started:** _____

Have you had > 5 sexual partners in your lifetime? ☐ No ☐ Yes **If yes, how many?** _____

Sexual Orientation _____

Are you currently using birth control? ☐ No ☐ Yes ☐ Trying to get pregnant
Current birth control: _____ **Are you satisfied with it:** ☐ No ☐ Yes

Past Birth control methods:

Condoms	☐	Birth control pills	☐	Withdrawal	☐	Tubal Ligation	☐
Diaphragm	☐	Patch	☐	Rhythm	☐	Vasectomy	☐
Vaginal Film	☐	Vaginal Ring	☐	IUD	☐	Essure	☐

PREGNANCY HISTORY

	Number		Number		Number
Total times pregnant		Full term deliveries		Cesarean sections	
Miscarriages		Deliveries before 37 weeks		Forceps or vacuums	
Abortions		Living children			

Describe any special pregnancy problems:

PERSONAL MEDICAL HISTORY

MAJOR ILLNESSES	YES		YES		YES
Diabetes		Heart Disease		Anxiety	
High Blood Pressure		High cholesterol		Depression	
GI Reflux disease		Hepatitis		Seizures	
Other GI disease		Liver problem		Asthma	
Fibroids		Kidney infections/stones		Lung disease	
Endometriosis		Arthritis		Tuberculosis	
Osteopenia		Joint Pain		Thyroid disease	
Osteoporosis		Fracture		Clotting disorder	
Cancer (Type)					

Add others/Explain:

SURGICAL HISTORY

SURGERY	YEAR	SURGERY	YEAR

FAMILY HISTORY

MAJOR ILLNESSES	YES		YES		YES
Diabetes		Heart Disease		Anxiety	
High Blood Pressure		High cholesterol		Depression	
GI Reflux Disease		Hepatitis		Seizures	
Other GI disease		Liver problem		Asthma/	
Fibroids		Kidney infections/stones		Lung disease	
Endometriosis		Arthritis		Tuberculosis	
Osteopenia		Joint pain		Thyroid disease	
Osteoporosis		Fracture		Clotting disorder	
Cancer (Type)					
Add others/Explain:					

SOCIAL HISTORY

Personal Profile

Occupation: _____ **Preferred Language:** _____

Birth Place: _____ **Ethnicity:** _____

Married ☐ **Single** ☐ **Divorced** ☐ **Widowed** ☐ **Significantly Involved** ☐ **Domestic Partner** ☐

Education Level: High school ☐ **College** ☐ **Graduate degree** ☐ **Other** ☐

Exercise: Yes ☐ **No** ☐

How often _____ **Type** _____

Special Diet: Yes ☐ **No** ☐ **Type** _____

Hobbies, Interests, Goals: _____

_____

Habits

Smoking: Yes ☐ **No** ☐ **Packs/day** _____ **Years** _____ **Quit when:** _____

Alcohol: Yes ☐ **No** ☐ **Drinks/day** _____ **Drinks/week:** _____ **Quit when:** _____

Drug Use: Yes ☐ **No** ☐ **Type** _____ **Years** _____ **Quit when:** _____

Caffeine: Yes ☐ **No** ☐ **Cups per day** _____ **Cups per week:** _____

Do you use seatbelts? Yes ☐ **No** ☐ **Do you use sunscreen? Yes** ☐ **No** ☐

Do you own guns in your home? Yes ☐ **No** ☐ **If yes, is it in a secure location? Yes** ☐ **No** ☐

Personal Safety

Yes ☐ **No** ☐ **Has anyone close to you ever threatened to hurt you?**

Yes ☐ **No** ☐ **Has anyone ever hit, kicked, choked or hurt you physically?**

Yes ☐ No ☐	Has anyone, including you partner, every forced you to have sex?
Yes ☐ No ☐	Are you ever afraid of your partner?

REVIEW OF SYSTEMS

1. CONSTITUTIONAL		NOTES
Fever	☐	
Chills	☐	
Fatigue	☐	
Weight Loss	☐	
Weight gain	☐	
2. EYES		
Changes in vision	☐	
Double vision	☐	
3. ENT/ MOUTH		
Ear aches	☐	
Ringing in the ears	☐	
Sinus problems	☐	
Sore throat	☐	
Mouth sores	☐	
Dry Mouth	☐	
4. CARDIOVASCULAR		
Chest pain	☐	
Difficulty breathing on exertion	☐	
Swelling of legs	☐	
Palpitations	☐	
Heart Murmurs	☐	
5. RESPIRATORY		
Wheezing	☐	
Spitting up blood	☐	
Shortness of breath	☐	
Cough	☐	
6. GASTROINTESTINAL		
Diarrhea	☐	
Constipation	☐	
Nausea/vomiting	☐	
Bloody stool	☐	
Abdominal pain	☐	
Indigestion	☐	
Bloating	☐	
Liver problem/Hepatitis	☐	
7. GENITOURINARY		
Blood in urine	☐	
Pain with urination	☐	
Urgency	☐	
Urinary Frequency	☐	
Urinary Incontinence	☐	

7. GENITOURINARY		NOTES
Abnormal Bleeding	☐	
Vaginal discharge/ odor	☐	
Vaginal itching/ burning	☐	
Pelvic pain	☐	
Menstrual cramps	☐	
Painful intercourse	☐	
Genital lump	☐	
Fertility concerns	☐	
Menopausal concerns	☐	
8. MUSCULOSKELETAL		
Muscle weakness	☐	
Joint stiffness	☐	
Joint pain	☐	
Joint swelling	☐	
9. SKIN/ BREAST		
Breast pain	☐	
Nipple discharge	☐	
Breast lumps	☐	
Rash	☐	
Ulcers	☐	
11. PSYCHIATRIC		
Depression	☐	
Mood swings	☐	
Anxiety	☐	
Suicidal thoughts	☐	
Homicidal thoughts	☐	
12. ENDOCRINE		
Abnormal thirst	☐	
Hot flashes	☐	
Tremors	☐	
Cold/ heat intolerance	☐	
13. HEMATOLOGIC		
Frequent bruising	☐	
Cuts do not stop bleeding	☐	
Enlarged lymph nodes	☐	