GYNECOLOGIC INTAKE HISTORY

NAME_____ BIRTH DATE ____/____/_____. DATE____/___/_____

ADDRESS_____

CITY_____ STATE/ZIP_____

HOME TEL: ( )_____ WORK TEL: ( )_____

EMPLOYER: _____ INSURANCE:_____

NAME OF SPOUSE/PARTNER:_____ REFERRED BY:_____

REVIEW OF SYSTEMS

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST OR OFTEN

1. CONSTITUTIONAL	CURRENTLY	PAST	NOTES
Weight loss	☐	☐	
Weight gain	☐	☐	
Fever	☐	☐	
Fatigue	☐	☐	

2. EYES			
Double vision	☐	☐	
Spots before eyes	☐	☐	
Vision changes	☐	☐	

3. ENT/MOUTH			
Ear aches	☐	☐	
Ringing in ears	☐	☐	
Sinus problems	☐	☐	
Sore throat	☐	☐	
Mouth sores	☐	☐	
Dental problems	☐	☐	

4. CARDIOVASCULAR			
Painful breathing	☐	☐	
Chest pain	☐	☐	
Difficult breathing of exertion	☐	☐	
Swelling of legs	☐	☐	
Palpitations of heart	☐	☐	

5. RESPIRATORY			
Wheezing	☐	☐	
Spitting up blood	☐	☐	
Shortness of breath	☐	☐	
Cough, chronic	☐	☐	

6. GASTROINTESTINAL			
Diarrhea, frequent	☐	☐	
Bloody stool	☐	☐	
Nausea/vomiting	☐	☐	
Constipation	☐	☐	

7. GENITOURINARY			
Blood in urine	☐	☐	
Pain with urination	☐	☐	
Urgency	☐	☐	
Frequency of urination	☐	☐	
Incomplete emptying	☐	☐	
Stress Incontinence	☐	☐	
Abnormal period	☐	☐	
Painful intercourse	☐	☐	

8. MUSKULOSKELETAL			
Muscle weakness	☐	☐	

9. SKIN/BREAST			
Pain in breast	☐	☐	
Discharge	☐	☐	
Masses	☐	☐	
Rash	☐	☐	
Ulcers	☐	☐	

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST OR OFTEN

10. NEUROLOGICAL	CURRENTLY	PAST
Dizziness	☐	☐
Seizures	☐	☐
Numbness	☐	☐
Trouble walking	☐	☐

11. PSYCHIATRIC		
Depression	☐	☐
Crying, frequent	☐	☐

12. ENDOCRINE		
Dry skin	☐	☐
Abnormal thirst	☐	☐
Hot flashes	☐	☐

13. HEMATOLOGIC/ LYMPHATIC		
Bruises, frequent	☐	☐
Cuts do not stop bleeding	☐	☐
Enlarged lymph nodes	☐	☐

14. ALLERGIC/ IMMUNOLOGIC		
Allergies	☐	☐
Drugs, other	☐	☐

PERSONAL PAST HISTORY

MAJOR ILLNESSES	YES	NO	MAJOR ILLNESSES	YES	NO
Asthma	☐	☐	Cancer	☐	☐
Pneumonia	☐	☐	Ulcers	☐	☐
Chronic Lung Disease	☐	☐	Depression/ Anxiety	☐	☐
Kidney Infections/ Stones	☐	☐	Anemia/ Blood Transfusions	☐	☐
Tuberculosis	☐	☐	Seizures/ /Epilepsy	☐	☐
Venereal Disease	☐	☐	Bowel Trouble	☐	☐
Heart Trouble/ Murmur	☐	☐	Glaucoma	☐	☐
Diabetes	☐	☐	Arthritis/ Joint Pain	☐	☐
High Blood Pressure	☐	☐	Fracture	☐	☐
Stroke	☐	☐	Hepatitis/ Yellow jaundice	☐	☐
Rheumatic Fever	☐	☐	Thyroid Disease	☐	☐

OPERATIONS/ HOSPITALIZATIONS

Reason	Date	Reason	Date

INJURIES /ILLNESSES

Type	Date	Type	Date

LAST IMMUNIZATION OR TEST

	Date		Date
Tetanus		Pneumonia	
Flu Shot		TB Skin Test	

OB/GYN HISTORY Last pap

	Date	Last Mammo	Date
Births		Abortions	
Miscarriages		Living Children	

Menarche cycle days h/o ocp h/o hrt h/o std

CURRENT MEDICATIONS

Drug Name	Dosage	Drug Name	Dosage

FAMILY HISTORY

ILLNESS	YES	Relative	ILLNESS	YES	Relative
Diabetes	☐		Drinking Problems	☐	
Stroke	☐		Breast Cancer	☐	
Heart Disease	☐		Colon Cancer	☐	
High Blood Pressure	☐		Ovarian Cancer	☐	

SOCIAL HISTORY

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 _____
School Completed High School ☐ College ☐ Graduate Degree ☐ Other ☐
Current or most recent job_____

PERSONAL SAFETY

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

MEDICARE "HIGH RISK" CRITERIA

Have you ever been treated for any of the following infections?
☐ Vaginosis ☐ Genital Warts ☐ Chlamydia ☐ Herpes ☐ Trichomonas ☐ Gonorrhea ☐ Syphilis

Have you had a Pap smear in the last 7 years?	Yes ☐	No ☐	
Have you ever had an abnormal Pap smear?	Yes ☐	No ☐	When? _____
Did you begin sexual activity before you were 16 years old?	Yes ☐	No ☐	
Have you had more than 5 sexual partners in your lifetime?	Yes ☐	No ☐	
Did your mother take the drug DES when she was pregnant with you?	Yes ☐	No ☐	
Have you ever tested positive for HIV?	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:_____