

GYNECOLOGY INTAKE FORM

DATE: ____/____/____ AGE: _____

NAME: _____ BIRTH DATE: ____/____/____

ADDRESS: _____ CITY STATE/ZIP

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

PRIMARY CARE MD: _____ HEIGHT: _____

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? <input type="checkbox"/> No <input type="checkbox"/> Yes When? _____								
What abnormality? _____								
Have you ever been treated for: <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Chlamydia</td> <td style="width: 33%;"><input type="checkbox"/> Gonorrhea</td> <td style="width: 33%;"><input type="checkbox"/> Genital Warts</td> </tr> <tr> <td><input type="checkbox"/> Herpes</td> <td><input type="checkbox"/> Trichomonas</td> <td><input type="checkbox"/> Syphilis</td> </tr> </table>			<input type="checkbox"/> Chlamydia	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Genital Warts	<input type="checkbox"/> Herpes	<input type="checkbox"/> Trichomonas	<input type="checkbox"/> Syphilis
<input type="checkbox"/> Chlamydia	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Genital Warts						
<input type="checkbox"/> Herpes	<input type="checkbox"/> Trichomonas	<input type="checkbox"/> Syphilis						

Have you ever tested positive for HIV?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Did you mother take the drug DES when she was pregnant with you?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Are you currently sexually active?	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Never
Did you begin sexual activity before 16yo?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
		If yes, Age started: _____
Have you had > 5 sexual partners in your lifetime?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
		If yes, how many? _____
Sexual Orientation		
Are you currently using birth control?	<input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Trying to get pregnant
Current birth control: _____	Are you satisfied with it: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Past Birth control methods:		
Condoms <input type="checkbox"/>	Birth control pills <input type="checkbox"/>	Withdrawal <input type="checkbox"/>
Diaphragm <input type="checkbox"/>	Patch <input type="checkbox"/>	Rhythm <input type="checkbox"/>
Vaginal Film <input type="checkbox"/>	Vaginal Ring <input type="checkbox"/>	IUD <input type="checkbox"/>
		Tubal Ligation <input type="checkbox"/>
		Vasectomy <input type="checkbox"/>
		Essure <input type="checkbox"/>

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

SOCIAL HISTORY

Personal Profile	
Occupation: _____	Preferred Language: _____
Birth Place: _____	Ethnicity: _____
Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Significantly Involved <input type="checkbox"/> Domestic Partner <input type="checkbox"/>	
Education Level: High school <input type="checkbox"/> College <input type="checkbox"/> Graduate degree <input type="checkbox"/> Other <input type="checkbox"/>	
Exercise: Yes <input type="checkbox"/> No <input type="checkbox"/>	
How often _____ Type _____	
Special Diet: Yes <input type="checkbox"/> No <input type="checkbox"/> Type _____	
Hobbies, Interests, Goals: _____	
Habits	
Smoking: Yes <input type="checkbox"/> No <input type="checkbox"/> Packs/day _____ Years _____ Quit when: _____	
Alcohol: Yes <input type="checkbox"/> No <input type="checkbox"/> Drinks/day _____ Drinks/week: _____ Quit when: _____	
Drug Use: Yes <input type="checkbox"/> No <input type="checkbox"/> Type _____ Years _____ Quit when: _____	
Caffeine: Yes <input type="checkbox"/> No <input type="checkbox"/> Cups per day _____ Cups per week: _____	
Do you use seatbelts? Yes <input type="checkbox"/> No <input type="checkbox"/> Do you use sunscreen? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Do you own guns in your home? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, is it in a secure location? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Personal Safety	
Yes <input type="checkbox"/> No <input type="checkbox"/> Has anyone close to you ever threatened to hurt you?	
Yes <input type="checkbox"/> No <input type="checkbox"/> 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	7. GENITOURINARY		NOTES
Fever	<input type="checkbox"/>			Abnormal Bleeding	
Chills	<input type="checkbox"/>	Vaginal discharge/ odor		<input type="checkbox"/>	
Fatigue	<input type="checkbox"/>	Vaginal itching/ burning		<input type="checkbox"/>	
Weight Loss	<input type="checkbox"/>	Pelvic pain		<input type="checkbox"/>	
Weight gain	<input type="checkbox"/>	Menstrual cramps		<input type="checkbox"/>	
2. EYES			Painful intercourse	<input type="checkbox"/>	
Changes in vision	<input type="checkbox"/>		Genital lump	<input type="checkbox"/>	
Double vision	<input type="checkbox"/>		Fertility concerns	<input type="checkbox"/>	
3. ENT/ MOUTH			Menopausal concerns	<input type="checkbox"/>	
Ear aches	<input type="checkbox"/>		8. MUSCULOSKELETAL		
Ringing in the ears	<input type="checkbox"/>		Muscle weakness	<input type="checkbox"/>	
Sinus problems	<input type="checkbox"/>		Joint stiffness	<input type="checkbox"/>	
Sore throat	<input type="checkbox"/>		Joint pain	<input type="checkbox"/>	
Mouth sores	<input type="checkbox"/>		Joint swelling	<input type="checkbox"/>	
Dry Mouth	<input type="checkbox"/>	9. SKIN/ BREAST			
4. CARDIOVASCULAR		Breast pain	<input type="checkbox"/>		
Chest pain	<input type="checkbox"/>	Nipple discharge	<input type="checkbox"/>		
Difficulty breathing on exertion	<input type="checkbox"/>	Breast lumps	<input type="checkbox"/>		
Swelling of legs	<input type="checkbox"/>	Rash	<input type="checkbox"/>		
Palpitations	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>		
Heart Murmurs	<input type="checkbox"/>	11. PSYCHIATRIC			
5. RESPIRATORY		Depression	<input type="checkbox"/>		
Wheezing	<input type="checkbox"/>	Mood swings	<input type="checkbox"/>		
Spitting up blood	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>		
Shortness of breath	<input type="checkbox"/>	Suicidal thoughts	<input type="checkbox"/>		
Cough	<input type="checkbox"/>	Homicidal thoughts	<input type="checkbox"/>		
6. GASTROINTESTINAL			12. ENDOCRINE		
Diarrhea	<input type="checkbox"/>		Abnormal thirst	<input type="checkbox"/>	
Constipation	<input type="checkbox"/>		Hot flashes	<input type="checkbox"/>	
Nausea/vomiting	<input type="checkbox"/>		Tremors	<input type="checkbox"/>	
Bloody stool	<input type="checkbox"/>		Cold/ heat intolerance	<input type="checkbox"/>	
Abdominal pain	<input type="checkbox"/>		13. HEMATOLOGIC		
Indigestion	<input type="checkbox"/>		Frequent bruising	<input type="checkbox"/>	
Bloating	<input type="checkbox"/>		Cuts do not stop bleeding	<input type="checkbox"/>	
Liver problem/Hepatitis	<input type="checkbox"/>	Enlarged lymph nodes	<input type="checkbox"/>		
7. GENITOURINARY					
Blood in urine	<input type="checkbox"/>				
Pain with urination	<input type="checkbox"/>				
Urgency	<input type="checkbox"/>				
Urinary Frequency	<input type="checkbox"/>				
Urinary Incontinence	<input type="checkbox"/>				