How were you referred to our offic

❑ Friend ❑ Yellow Pages

❑ Doctor ____________________

❑ Other ____________________

Date Completed: ____________________

GYNECOLOGY INTAKE HISTORY

Name: ____________________ Birth Date: ____________________

Address: ____________________

City: ____________________ State, Zip: ____________________

Home Telephone: ____________________ Work Telephone: ____________________

Employer: ____________________ Insurance: ____________________

Social Security Number: ____________________

Marital Status: ____________________ Partner's Name: ____________________

Allergies: ____________________ Primary Care Physician: ____________________

FAMILY AND PERSONAL PAST HISTORY

MAJOR ILLNESS	Personal	Relative (specify)	No	MAJOR ILLNESS	Personal	No
Chronic Lung Disease				Sexually Transmitted Infection		
Kidney Infections/Stones				HIV		
Cancer: Ovarian				Ulcers		
Colon				Depression/anxiety		
Uterine				Anemia/Blood transfusions		
Breast				Seizures/convulsions/epilepsy		
Other:				Bowel trouble		
Heart trouble/murmur				Asthma		
Diabetes				Pneumonia		
High blood pressure				Arthritis		
Stroke				Bone fracture		
Osteoporosis				Hepatitis		
Thyroid disease				Other:		

OB/GYN HISTORY

(Please indicate all pregnancies including miscarriages, ectopics, etc.)

DATE	TYPE OF DELIVERY	LOCATION/MD	WEIGHT	NAME	COMPLICATIONS

OPERATIONS/HOSPITALIZATIONS

SURGERY OR REASON FOR ADMISSION	DATE	SURGERY OR REASON FOR ADMISSION	DATE

LAST IMMUNIZATION OR TESTS

(Please write in approximate date)

Tetanus ____________ Pneumonia ____________ Flu Shot ____________ TB Skin Test ____________

REVIEW OF SYSTEMS

Please note only for significant or abnormal symptoms)

SYMPTOM	Current	Past	NOTES
CONSTITUTIONAL			
Weight Change	❑	❑	
Fever	❑	❑	
EYES			
Spots before eyes	❑	❑	
Vision changes	❑	❑	
ENT/MOUTH			
Ear aches	❑	❑	
Ringing in ears	❑	❑	
Sinus Problems	❑	❑	
CARDIOVASCULAR/RESPIRATORY			
Chest pain	❑	❑	
Painful or difficult breathing	❑	❑	
Chronic cough with or without blood	❑	❑	
Swelling of legs	❑	❑	
Palpitations	❑	❑	
GASTROINTESTINAL			
Diarrhea, frequent	❑	❑	
Nausea/Vomiting	❑	❑	
Constipation	❑	❑	
Bloody Stool	❑	❑	
GENITOURINARY			
Abnormal urination	❑	❑	
Blood in urine	❑	❑	
Abnormal periods	❑	❑	
Painful intercourse	❑	❑	
Abnormal vaginal discharge	❑	❑	
Vaginal or vulvar pain	❑	❑	
MUSCULOSKELETAL			
Weakness	❑	❑	
Joint pain	❑	❑	
SKIN/BREAST			
Discharge or mass in breast	❑	❑	
Pain in breast	❑	❑	
Rash or skin abnormalities	❑	❑	
OTHER	❑	❑	

CURRENT MEDICATIONS AND DOSES

SOCIAL HISTORY

Smoking	❑ Yes	❑ No	Packs per day ________ Years of smoking ________
Alcohol	❑ Yes	❑ No	Drinks per week ________
Drug Use	❑ Yes	❑ No	Type ________
Seat Belt Use	❑ Yes	❑ No	
Regular Exercise	❑ Yes	❑ No	Per week of aerobic ________ Other exercise ________
Victim of Abuse	❑ Yes	❑ No	Sexual, physical, emotional ________

Physician Signature ________________ Date Reviewed ________

Physician Signature ________________ Date Reviewed ________

Physician Signature ________________ Date Reviewed ________

Physician Signature ________________ Date Reviewed ________