GYNECOLOGIC INTAKE HISTORY

NAME: _____ DATE: ___/___/___

ADDRESS: _____ BIRTH DATE: ___/___/___

CITY: _____ HOME TEL: ( ) _____

STATE/ZIP _____ WORK TEL: ( ) _____

EMPLOYER: _____ INSURANCE: _____

NAME OF SPOUSE/PARTNER _____ REFFERRED BY: _____

REVIEW OF SYSTEMS: PLEASE CHECK (√) APPROPRIATE BOX IF ANY OF THE FOLLOWING APPLY TO YOU NOW OR HAVE APPLIED IN THE PAST

	Currently	Past	Notes
1. Constitutional			
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 on exertion	☐	☐	
Swelling of legs	☐	☐	
Palpitations of heart	☐	☐	
5. Respiratory			
Wheezing	☐	☐	
Spitting up blood	☐	☐	
Shortness of breath	☐	☐	
Chronic cough	☐	☐	
6. Gastrointestinal			
Frequent diarrhea	☐	☐	
Blood stool	☐	☐	
Nausea/vomiting	☐	☐	
Constipation	☐	☐	
7. Genitourinary			
Blood in urine	☐	☐	
Pain with urination	☐	☐	
Urgency	☐	☐	
Frequency of urination	☐	☐	
Incomplete emptying	☐	☐	
Stress incontinence	☐	☐	
Abnormal periods	☐	☐	
Painful intercourse	☐	☐	
8. Musculoskeletal			
Muscle weakness	☐	☐	
9. Skin/Breast			
Pain in breast	☐	☐	
Discharge	☐	☐	
Masses	☐	☐	
Rash	☐	☐	
Ulcers	☐	☐	

REVIEW OF SYSTEMS (CONTINUED) PLEASE CHECK (√) APPROPRIATE BOX IF ANY OF THE FOLLOWING APPLY TO YOU NOW OR HAVE APPLIED IN THE PAST

	Currently	Past	Notes
10. Neurological			
Dizziness	☐	☐	
Seizures	☐	☐	
Numbness	☐	☐	
Trouble walking	☐	☐	
11. Psychiatric			
Depression	☐	☐	
Frequent crying	☐	☐	
12. Endocrine			
Dry skin	☐	☐	
Abnormal thirst	☐	☐	
Hot flashes	☐	☐	
13. Hematologic/lymphatic			
Frequent bruises	☐	☐	
Cuts that do not stop bleeding	☐	☐	
Enlarged lymph nodes	☐	☐	
14. Allergic/immunologic			
Allergies	☐	☐	
Drug allergy	☐	☐	

HEIGHT: WEIGHT:

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/convulsions/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 (DESCRIBE REASON FOR OPERATION/HOSPITALIZATION)

	Date		Date

INJURIES/ILLNESSES (DESCRIBE TYPE OF INJURY/ILLNESS)

	Date		Date

LAST IMMUNIZATION OR TEST

	Date		Date
Tetanus Flu Shot		Pneumonia TB Skin Test	

OB/GYN HISTORY

	Number		Number
Births Miscarriages		Abortions Living children	

CURRENT MEDICATIONS (LIST DRUG NAME[S] AND DOSAGE[S])

	Dosage(s)		Dosage(s)

FAMILY HISTORY: PLEASE CHECK (√) YES IF A FAMILY MEMBER HAS OR HAD ONE OF THESE ILLNESSES

Illness	Yes	No	Family Member	Illness	Yes	No	Family Member
Diabetes	☐	☐		Drinking Problem	☐	☐	
Stroke	☐	☐		Breast Cancer	☐	☐	
Heart Disease	☐	☐		Colon Cancer	☐	☐	
High Blood Pressure	☐	☐		Ovarian Cancer	☐	☐	

SOCIAL HISTORY: PERSONAL 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	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: Please check (√) if you have ever been treated for any of the following infections:

Vaginosis	☐	Genital Warts	☐	Chlamydia	☐
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?	☐	☐	If so, when? _____
Did you begin sexual activity before you were 16 years old?	☐	☐	
Have you had more than 5 sexual partners in your lifetime?	☐	☐	
Have you ever tested positive for the HIV virus?	☐	☐	
Did your mother take the drug DES when she was pregnant with you?	☐	☐	

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: _____