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Obstetrics, Gynecology, & Women's Health
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INTAKE HISTORY

NAME: _____ BIRTH DATE: _____ DATE: _____
ADDRESS: _____
CITY _____ STATE/ZIP: _____
HOME TEL: () _____ WORK TEL: () _____
EMPLOYER: _____ INSURANCE: _____
NAME OF SPOUSE/PARTNER: _____ REFERRED BY _____

PERSONAL PAST HISTORY

MAJOR ILLNESSES	Yes	No		Yes	No
Asthma			Cancer		
Thyroid Disease			Ulcers		
High Blood Pressure			Depression/anxiety		
Kidney Infections/stones			Anemia/Blood transfusions		
Blood Clots/Pulm. Embolism/DVT			Seizures/convulsions/epilepsy		
Heart attack/myocardial infarction			Bowel trouble/constipation/diarrhea		
Heart Disease/murmur			High Cholesterol/Lipid disorder		
Diabetes			Arthritis/joint pain		
COPD/Emphysema/Lung disease			HIV/AIDS		
Stroke			Hepatitis B or C		
Rheumatic Fever			Other Illnesses		

PAST SURGERIES/HOSPITALIZATIONS/ILLNESSES/INJURIES

Procedure/Reason	Month/Year	Procedure/Reason	Month/Year

OBSTETRIC HISTORY

Vaginal Births: _____ C-Sections: _____ Abortions: _____
Miscarriages: _____ Living children: _____

GYNECOLOGIC HISTORY

LAST MENSTRUAL PERIOD: / / NORMAL: Y N DURATION OF FLOW: DAYS FREQUENCY:
AGE OF FIRST PERIOD:
LAST PAP SMEAR: / / NORMAL: Y N HISTORY OF ABNORMAL PAP'S:
SEXUALLY ACTIVE: Y N NUMBER OF LIFETIME PARTNERS: AGE OF CURRENT PARTNER:
HISTORY OF SEXUALLY TRANSMITTED INFECTIONS (HIV, SYPHILIS, GENITAL HERPES, GENITAL WARTS, HEPATITIS B OR C, TRICHOMONIASIS)
Y N IF YES, WHICH: _____
IF YES, LAST TIME OF INFECTION/OUTBREAK: _____

CURRENT MEDICATIONS

Drug Name	Dosage	Drug Name	Dosage

DRUG ALLERGIES: NO YES WHICH? _____

FAMILY HISTORY

Illness	Yes	Relative	Illness	Yes	Relative
Diabetes			Drinking Problem		
Stroke			Breast Cancer		
Heart Disease			Colon Cancer		
High Blood Pressure			Ovary, Cervix, other Cancer		

SOCIAL HISTORY

Habits					
Smoking	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Packs per day _____	Years _____	
Alcohol	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Drinks per day _____	Drinks per week _____	
Drug Use	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
Seat Belt Use	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
Regular Exercise	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
Personal Profile					
Marital Status	Married <input type="checkbox"/>	Single <input type="checkbox"/>	Widowed <input type="checkbox"/>	Divorced <input type="checkbox"/>	
Number of Living Children	_____				
Number of people in household	_____				
School Completed	High School <input type="checkbox"/>	College <input type="checkbox"/>	Graduate Degree <input type="checkbox"/>	Other <input type="checkbox"/>	
Current or most recent job	_____				

REVIEW OF SYSTEMS

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST OR OFTEN				
	Yes	No	Occasional	NOTES
1. CONSTITUTIONAL				
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. EYES				
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Spots before eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vision changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. ENT/MOUTH				
Ear aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ringling in ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mouth sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dental problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. CARDIOVASCULAR				
Painful breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficult breathing on exertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling of legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Palpitations of heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. RESPIRATORY				
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Spitting up blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cough, chronic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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

GASTROINTESTINAL	Yes	No	OCCASIONAL	NOTES
Diarrhea, frequent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bloody stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

6. GENITOURINARY

Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pain with urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Urgency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Frequency of urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Incomplete emptying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stress incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Abnormal periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Painful intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

8. MUSCULOSKELETAL

Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Joint Aches/Pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

9. SKIN/BREAST

Pain in breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Masses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

10. NEUROLOGICAL

Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Trouble walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

11. PSYCHIATRIC

Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Crying, frequent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

12. ENDOCRINE

Dry skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Abnormal thirst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

13. HEMATOLOGIC/LYMPHATIC

Bruises, frequent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cuts do not stop bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Enlarged lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

14. ALLERGIC/IMMUNOLOGIC

Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Drugs, other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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: _____