GYNECOLOGIC INTAKE HISTORY

NAME:_____ BIRTHDATE: ____/____/____ 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		
Pneumonia			Ulcers		
Chronic Lung Disease			Depression/anxiety		
Kidney Infections/stones			Anemia/Blood transfers		
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

Reason	Date	Reason	Date

INJURIES/ILLNESSES

TYPE	Date	Type	Date

LAST IMMUNIZATION OR TEST

	Date		Date
Tetanus		Pneumonia	
Flu Shot		TB skin test	

OBGYN HISTORY

	Number		Number
Births		Abortions	
Miscarriages		Living Children	

CURRENT MEDICATIONS

Drug Name	Dosage	Drug Name	Dosage

Family History

Illness	Yes	Relative	Illness	Yes	Relative
Diabetes			Drinking Problem		
Stroke			Breast Cancer		
Heart Disease			Colon Cancer		
High Blood Pressure			Ovarian Cancer		

WHA #160-1/3 Rev. 04/12

Habits

Smoking	Yes	☐	No	☐	Packs per day_____	Years_____
Alcohol	Yes	☐	No	☐	Drinks per day_____	Drinks per week_____
Drug Use	Yes	☐	No	☐		
Seat Belt Use	Yes	☐	No	☐		
Regular Exercise	Yes	☐	No	☐		

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?

Yes ☐ No ☐ Has anyone ever hit, kicked, choked, or hurt you physically?

Yes ☐ No ☐ Has anyone, including your partner, ever forced you to have sex?

Yes ☐ No ☐ Are you ever afraid of your partner?

MEDICARE "HIGH RISK" CRITERIA

Have you ever been treated for any of the following infections?

☐ Vaginosis ☐ Genital warts ☐ Chlamydia ☐ Herpes ☐ Tichomonas ☐ Gonorrhea ☐ Syphilis

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

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 vefore eyes	☐	☐	
Vision changes	☐	☐	
3. ENT/Mouth			
Ear aches	☐	☐	
Ringing in ears	☐	☐	
Sinus problems	☐	☐	
Sore throat	☐	☐	
Mouth sores	☐	☐	
Dental problems	☐	☐	
4. Cadiovascular			
Painful breathing	☐	☐	
Chest pain	☐	☐	
Difficult breathing on 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 periods	☐	☐	
Painful intercourse	☐	☐	
8. Musculoskeletal			
Muscle weakness	☐	☐	
9. Skin/Breast	Currently	Past	Notes
Pain in breast	☐	☐	
Discharge	☐	☐	
Masses	☐	☐	
Rash	☐	☐	
Ulcers	☐	☐	
10. Neurological			
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	☐	☐	

Completed by: Patient ☐ Office Nurse ☐ Physician ☐

Signatue 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:

Date Reviewed: _____ Physician Signature:_____