GYNECOLOGICAL INTAKE HISTORY

NAME: _____ DATE: _____

ADDRESS: _____ D.O.B. _____

CITY: _____ HOME # _____

STATE/ZIP: _____ WORK # _____

EMPLOYER: _____ INSURANCE: _____

NAME OF SPOUSE/PARTNER _____ REFERRED BY: _____

REVIEW OF SYSTEMS: PLEASE CHECK ANY BOXES THAT APPLY TO YOU NOW OR HAVE APPLIED IN THE PAST

	Currently	Never	Past	Notes
1. Constitutional				
Weight Loss	☐	☐	☐	
Weight Gain	☐	☐	☐	
Fever	☐	☐	☐	
Fatigue	☐	☐	☐	
2. Eyes				
Double Vision	☐	☐	☐	
Spots before eyes	☐	☐	☐	
Vision changes	☐	☐	☐	
3. Ears/Nose/Throat/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	☐	☐	☐	

Patient Name _____

REVIEW OF SYSTEMS (CONTINUED): PLEASE CHECK ANY BOXES THAT APPLY TO YOU NOW OR HAVE APPLIED IN THE PAST

	Currently	Never	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	☐	☐	☐	

PERSON PAST HISTORY: PLEASE CHECK ANY BOXES THAT APPLY TO YOU NOW OR HAVE APPLIED IN THE PAST

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		PNEUMONIA	
FLU SHOT		TB SKIN TEST	
OTHER		OTHER	

OB/GYN HISTORY

	Number		Number
BIRTHS		MISCARRIAGES/ABORTIONS	
LIVING CHILDREN		ADOPTED CHILDREN	

CURRENT MEDICATIONS-LIST DRUG NAME(S) AND DOSGAGE(S)

	Dosage(s)		Dosage(s)
1)		4)	
2)		5)	
3)		6)	

Patient Name _____

FAMILY HISTORY: PLEASE CHECK 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 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?	□	□

Please check if you have ever been treated for any of the following infections:

Vaginosis	□	Genital Warts	□	Chlamydia	□
Trichomonas	□	Gonorrhea	□	Syphilis	□

	Yes	No	Dates
Have you had a Pap smear in the last 7 years?	□	□	
Have you ever had an abnormal pap smear test?	□	□	
Did you begin sexual activity before you were 16 years old?	□	□	
Have you had more than five 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?	□	□	
Have you ever had a colonoscopy?	□	□	
When was you last mammogram?	□	□	

Completed By: Patient □ Guardian □ Physician □ Office Staff/Other □

Signature of patient: _____

Name of Guardian _____ Signature _____

Physician Signature: _____

Date reviewed by physician with patient: _____

Annual Review of History

Date reviewed:_____ Physician Signature: _____

Date reviewed:_____ Physician Signature: _____

Date reviewed:_____ Physician Signature: _____

Date reviewed:_____ Physician Signature: _____