FOR OFFICE USE ONLY

- ☐ NEW PATIENT
- ☐ ESTABLISHED PATIENT
- ☐ CONSULTATION

PATIENT INTAKE HISTORY

PATIENT NAME:	BIRTH DATE: / /	DATE: / /
ADDRESS:		
CITY:	STATE/ZIP:	
HOME TELEPHONE: ( )	WORK TELEPHONE: ( )	
EMPLOYER:	INSURANCE CO:	POLICY NO:
NAME YOU WOULD LIKE TO USE:	PRIMARY LANGUAGE:	
NAME OF SPOUSE/PARTNER:	EMERGENCY CONTACT:	
NAME OF SPOUSE/PARTNER:	RELATIONSHIP:	
	HOME TELEPHONE: ( )	
	WORK TELEPHONE: ( )	
REFERED BY:		
WHY HAVE YOU COME TO THE OFFICE TODAY?		
IS THIS IS A NEW PROBLEM?		
PLEASE DESCRIBE YOUR PROBLEM, INCLUDING WHERE IT IS, HOW SEVERE IT IS, AND HOW LONG IT HAS LASTED:		

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.

GYNECOLOGICAL HISTORY

	PHYSICIAN'S NOTES
LAST NORMAL MENSTRUAL PERIOD (FIRST DAY):	
AGE PERIODS BEGAN:	
LENGTH OF PERIODS (NUMBER OF DAYS OF BLEEDING):	
NUMBER OF DAYS BETWEEN PERIODS:	
ANY RECENT CHANGES IN PERIODS?	
ARE YOU CURRENTLY SEXUALLY ACTIVE?	
HAVE YOU EVER HAD A STD?	
NUMBER OF SEXUAL PARTNERS (LIFETIME):	
PRESENT METHOD OF BIRTH CONTROL:	
HAVE YOU EVER USED AN IUD OR BIRTH CONTROL PILLS?	
IF YES, FOR HOW LONG?	
WHEN WAS YOUR LAST PAP TEST?	
WHAT WAS THE RESULT?	
HAVE YOU EVER HAD AN ABNORMAL PAP TEST?	
DO YOU DO BREAST SELF-EXAMINATIONS?	
HAVE YOU BEEN EXPOSED TO DIETHYLSTILBESTROL (DES)?	

PATIENT INTAKE HISTORY (PAGE 2)

PATIENT NAME:	BIRTH DATE: / /	DATE: / /

OBSTETRIC HISTORY

	NO.		NO.		NO.
PREGNANCIES		ABORTIONS		MISCARRIAGES	
PREMATURE BIRTHS (<37 WKS)		LIVE BIRTHS		LIVING CHILDREN	

NO.	BIRTH DATE	WEIGHT AT BIRTH	BABY'S SEX	WEEKS PREGNANT	TYPE OF DELIVERY (VAGINAL, CESEREAN)	PHYSICIAN'S NOTES
1						
2						
3						
4						

ANY PREGNANCY COMPLICATIONS?

☐ DIABETES ☐ HYPERTENSION/HIGH BLOOD PRESSURE ☐ PREECLAMPSIA/TOXEMIA ☐ OTHER

ANY HISTORY OF DEPRESSION BEFORE OR AFTER PREGNANCY? ☐ NO ☐ YES, HOW TREATED

CURRENT MEDICATIONS

(Including hormones, vitamins, herbs, nonprescription medications)

DRUG NAME	DOSAGE	WHO PRESCRIBED	DRUG NAME	DOSAGE	WHO PRESCRIBED

FAMILY HISTORY

MOTHER: ☐ LIVING ☐ DECEASED-CAUSE AGE | FATHER: ☐ LIVING ☐ DECEASED-CAUSE AGE:

SIBLINGS: NUMBER LIVING: NUMBER DECEASED: CAUSE(S)/ AGE(S):

CHILDREN: NUMBER LIVING: NUMBER DECEASED: CAUSE(S)/ AGE(S):

ILLNESS	YES	WHICH RELATIVE(S) AND AGE OF ONSET			PHYSICIAN'S NOTES		
DIABETES	☐						
STROKE	☐						
HEART DISEASE	☐						
BLOOD CLOTS IN LUNGS OR LEGS	☐						
HIGH BLOOD PRESSURE	☐						
HIGH CHOLESTEROL	☐						
OSTEOPOROSIS (WEAK BONES)	☐						
HEPATITIS	☐						
HIV/ AIDS	☐						
TUBERCULOSIS	☐						
BIRTH DEFECTS	☐						
ALCOHOL OR DRUG PROBLEMS	☐						
BREAST CANCER	☐						
COLON CANCER	☐						
OVARIAN CANCER	☐						
UTERINE CANCER	☐						
MENTAL ILLNESS/ DEPRESSION	☐						
ALZHEIMER'S DESEASE	☐						
OTHER	☐						

PATIENT INTAKE HISTORY (PAGE 3)

PATIENT NAME:	BIRTH DATE: / /	DATE: / /

SOCIAL HISTORY

	YES	NO	PHYSICIAN'S NOTES
EVER SMOKED? CURRENT SMOKING: PACKS PER DAY: YEARS:	☐	☐	
ALCOHOL:DRINKS/DAY: DRINKS/WEEK: TYPE OF DRINK:	☐	☐	
DRUG USE	☐	☐	
SEAT BELT USE	☐	☐	
REGULAR EXERCISE: HOW LONG AND HOW OFTEN?	☐	☐	
DAIRY PRODUCT INTAKE AND/OR CALCIUM: DAILY INTAKE?	☐	☐	
HEALTH HAZARDS AT WORK OR HOME?	☐	☐	
HAVE YOU BEEN SEXUALLY ABUSED/THREATENED/HURT BY ANYONE?	☐	☐	
DO YOU HAVE AN ADVANCE DIRECTIVE (LIVING WILL)?	☐	☐	
ARE YOU AN ORGAN DONOR?	☐	☐	

PERSONAL PROFILE

MARITAL STATUS: ☐ MARRIED ☐ LIVING WITH PARTNER ☐ SINGLE ☐ WIDOWED ☐ DIVORCED

NUMBER OF LIVING CHILDREN:

NUMBER OF PEOPLE IN THE HOUSEHOLD:

SCHOOL COMPLETED: ☐ HIGH SCHOOL ☐ SOME COLLEGE/ AA DEGREE ☐ COLLEGE ☐ GRADUATE DEGREE ☐ OTHER

CURRENT OR MOST RECENT JOB:

TRAVEL OUTSIDE THE UNITED STATES? LOCATION(S)?

PERSONAL PAST HISTORY OF ILLNESSES

MAJOR ILLNESSES	YES	NO	NOT SURE	PHYSICIAN'S NOTES
ASTHMA				
PNEUMONIA/LUNG DISEASE				
KIDNEY INFECTIONS/ STONES				
TUBERCULOSIS				
FIBROIDS				
STD/ CHLAMYDIA				
INFERTILITY				
HIV/ AIDS				
HEART ATTACK/ DISEASE				
DIABETES				
HIGH BLOOD PRESSURE				
STROKE				
RHEUMATIC FEVER				
BLOOD CLOTS IN LUNGS OR LEGS				
EATING DISORDERS				
AUTOIMMUNE DISEASE (LUPUS)				
CHICKENPOX				
CANCER				
REFLUX/ HIATAL HERNIA/ (LUPUS)				
DEPRESSION/ ANXIETY				
ANEMIA				
BLOOD TRANSFUSIONS				
SEIZURES/ CONVULSIONS/ EPILEPSY				
BOWEL PROBLEMS				
GLAUCOMA				
CATARACTS				
ARTHRITIS/JOINT PAIN/BACK PROBLEM				
BROKEN BONES				
HEPATITIS/YELLOW JAUNDICE/LIVER DIS.				
THYROID DISEASE				