Patient Intake Form

Name			
Birthdate		Age	

Reason for Visit Today

Allergies

GYN History

Last menstrual period			
Age of first period			
Number of days between periods			
Length of period (days)			
Describe your periods(heavy, clots, irreg, etc)			
Method of birth control			
Have you ever used birth control pills? Y N		IUD? Y N	DepoProvera? Y N
Last Pap smear		Result	
Have you ever had an abnormal pap smear? Y N		Result	
Last Mammogram		Result	
Last Colonoscopy/Barium enema/Sigmoidoscopy			
Last Bone density scan/DEXA			
Have you ever had a sexually transmitted disease (gonorrhea, chlamydia, syphilis, herpes, genital warts?) Y N			
Have you ever had problems with infertility? Y N			
Have you ever had endometriosis? Y N			
Have you ever had fibroids? Y N			
Would you take blood or blood products in an emergency? Y N			

Obstetric History

	Number		Number		Number
Pregnancies		Abortions		Miscarriages	
Premature births (<37 weeks)		Live births		Living Children	

Birth date	Birth Weight	Gender	Weeks preg	Delivery Type		Notes

Current Medications

Name	Dose	Frequency	Who prescribed

Patient Name_____
Patient ID Number_____

Social History

	Yes	No	Explain
Smoking			
Alcohol			
Drug use			
Regular exercise			
Physical or sexual abuse			
Advanced directive or living will			
Organ donor			

Past Medical and Family History

Do you or anyone in your family have..	Yes	No	Explain
Asthma/Bronchitis			
Emphysema/COPD			
High cholesterol/lipids			
Heart defects/arrhythmias			
Heart attack/disease			
Diabetes			
High Blood Pressure			
Stroke			
Blood Clots/Bleeding Disorders			
Depression/Anxiety			
Psychiatric Disorders			
Anemia/Blood Transfusion			
Seizures/Epilepsy			
Intestinal/bowel/colon Disorders			
Hepatitis/Liver Disease			
Thyroid Disease			
Gallbladder Disease			
Alzheimer's Disease/Dementia			
Migraines/Headaches			
Cancer			
Other			

Operations/Hospitalizations

Reason		Date	Hospital

Immunizations

	Date	Reactions
Tetanus		
MMR		
Influenza		
Pneumovax		
PPD		
Hepatitis B		

Review of Systems			
	Yes	No	Notes
Chest pain/pressure			
Shortness of breath			
Swelling in legs			
Palpitations			
Rapid heartrate			
Weight loss/gain			
Fever/Chills/Night Sweats			
Fatigue			
Rash			
Abnormal moles			
Heat/cold Intolerance			
Frequent bruising			
Uncontrolled thirst			
Hearing loss/deafness			
Mouth sores			
Diarrhea			
Constipation			
Nausea/Vomiting			
Bloody stool			
Bloody urine			
Painful urination			
Strong urgency to urinate			
Frequent urination			
Involuntary urine loss			
Muscle or joint pain			
Dizziness			
Numbness			
Trouble walking			
Abnormal bleeding			
Painful periods			
Hot flashes			
Painful intercourse			
Pain in breast			
Nipple discharge			
Lumps in breast			
Blurred/spotty vision			
Depression/Anxiety			
Difficulty breathing			
Wheezing			
Coughing up blood			
Chronic cough			

Patient Name_____
Patient ID Number_____