GYNECOLOGICAL INTAKE HISTORY

NAME: _____ DATE: _____

ADDRESS: _____ BIRTHDATE: _____

CITY: _____ HOME TEL: _____

STATE/ZIP: _____ WORK TEL: _____

EMPLOYER: _____ INSURANCE: _____

SPOUSE/PARTNER: _____ REFERRED BY: _____

PLEASE CHECK (✓) APPROPRIATE BOX IF ANY OF THE FOLLOWING APPLY TO YOU NOW OR HAVE APPLIED IN THE PAST

		Currently	Past	Notes
1	**CONSTITUTIONAL**			
	Weight loss	☐	☐	
	Weight gain	☐	☐	
	Fever	☐	☐	
	Fatigue	☐	☐	
2	**EYES**			
	Double vision	☐	☐	
	Spots before eyes	☐	☐	
	Vision changes	☐	☐	
3	**ENT/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	☐	☐	
	Spittingup 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	☐	☐	

PLEASE CHECK (✓) APPROPRIATE BOX IF ANY OF THE FOLLOWING APPLY TO YOU NOW OR HAVE APPLIED IN THE PAST

		Currently	Past	Notes
10	**NEUROLOGICAQL**			
	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	☐	☐	

PERSONAL PAST HISTORY

MAJOR ILLNESSES			**MAJOR ILLNESSES**		
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

MENSTRUAL HISTORY

Age at onset:

Regular ☐ Irregular ☐

Cycle: _____ days (start to finish)

Pain/cramps: Yes ☐ No ☐

Usual duration: _____ days

Flow: Heavy ☐ Medium ☐ Light ☐

OB/GYN HISTORY

Number		Number
Births	Abortions	
Miscarriages	Living children	

Current Medications (List drug name(s) and dosage(s)

Dosage(s)	Dosage(s)

FAMILY HISTORY

PLEASE CHECK (✓)YES IF A FAMILY MEMBER HAS OR HAD ONE OF THESE ILLNESES

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 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?	☐	☐
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?	☐	☐

MEDICARE "HIGH RISK" CRITERIA

PLEASE CHECK (✓) IF YOU HAVE EVER BEEN TREATED FOR ANY OF THE FOLLOWING INFECTIONS:

Vaginosis	☐	Genital warts	☐	Chlamydia	☐
Trichomonas	☐	Gonorrhea	☐	Syphilis	☐

	YES	NO	
Have you had a Pap smear in the last 7 years?	☐	☐	
Have you ever had an abnormal Pap smear test?	☐	☐	If so, when? _____
Did you begin sexual activity before you were 16 years old?	☐	☐	
Have you had more than 5 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?	☐	☐	

Complete 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: _____