PLEASE *return this form to FRONT DESK when completed* ** Date of Visit ____________________

GYNECOLOGY INTAKE SHEET

(NEW PATIENTS or Patients not seen for more than a year)

REASON FOR VISIT:

_______ Annual Physical/Preventative Exam
_______ Abnormal Bleeding
_______ Vaginal Discharge
_______ Pain with intercourse
_______ Painful periods
_______ Urinary leaking or other problems
_______ Pelvic Prolapse
_______ PMS/mood changes with periods
_______ Abnormal Ultrasound/mass or cyst
_______ Pelvic Pain
_______ Other:
(Please describe): ____

_______ Vulvar itching/discomfort
_______ Abnormal PAP smear
_______ Contraception/Family Planning
_______ No period for more than 3 months
_______ Diminished sex drive
_______ Difficulty conceiving
_______ Recurrent pregnancy loss
_______ Menopausal Symptoms/hot flashes
_______ Menstrual Migraines
_______ Pregnancy Complication
_______ Prenatal Care

PAST MEDICAL HISTORY: (Please circle if you have (or have had) the following medical conditions)

Alcoholism
Anesthetic Complications
Anxiety
Arthritis
Asthma
Birth Defects
Bleeding Disorder
Clotting Disorder
Depression
Thyroid Disorder: Hypo / Hyper
Diabetes
Drug Abuse
GERD
Hepatitis
High Blood Pressure
High Cholesterol
Kidney Problems
Migraines
Osteoporosis
Overweight
Seizure Disorder
Stroke

Cancer ____(type)
Other: ____
____

SURGICAL HISTORY AND DATES: ◯ None (includes Tubal Ligation and C/S)

______ ________________________________ ______ ________________________________
______ ________________________________ ______ ________________________________
______ ________________________________ ______ ________________________________
______ ________________________________ ______ ________________________________
______ ________________________________ ______ ________________________________

MEDICATIONS/SUPPLEMENTS:

(Please list any medications you are currently taking (including BC pills and over the counter drugs/vitamins/supplements)

Name of Medication	Dose/mg/mcg	When Started	Why Prescribed	Any side effects?

ALLERGIES TO MEDICATIONS: ◯ **No Known Drug Allergies** (If so, state reactions)

Med ____________________________ Reaction ____________________
Med ____________________________ Reaction ____________________
Med ____________________________ Reaction ____________________

GYNECOLOGICAL HISTORY:

When was the **FIRST** day of your last menstrual period **(LMP)** ? _____________

MENSTRUAL HISTORY:

Days of flow ________ *FLOW* : ○ Light ○ Moderate ○ Heavy Menopause _________ (year)
Length of Menstrual Cycle _________(Day 1 to Day 1) Menarche __________ (Age at first period)
Pain or cramps? Y / N Any spotting between periods? Y / N After intercourse? Y / N

Are you sexually active? Yes Not Currently Never **Gardasil vaccine?** Y / N 1 2 3 shots?
Have you ever had an STD? (Please circle and date diagnosed) NEVER _____
Chlamydia Gonorrhea Herpes Syphilis Trichomonas HIV HPV (dysplasia or genital warts)

PLEASE CIRCLE THE FORM OF BIRTH CONTROL YOU AND YOUR PARTNER USE:
VASECTOMY TUBAL LIGATION IUD CONDOMS ORAL CONTRACEPTIVE HYSTERECTOMY NONE
NUVARING NEXPLANON PATCH DEPO INJECTION NFP OTHER: ________________________

When was your last: ***Result***
PAP smear ________________ _______
Mammogram ______________ _______
Colonoscopy ______________ _______
Bone Density/ DEXA ________ _______

Have you ever had an abnormal PAP? Y / N
How was it treated? Repeat PAP LEEP Cryo (circle)
Any breast biopsies? Y / N

Have you had any blood work performed? Y / N

PREVIOUS PREGNANCIES:

How many times have you been pregnant? _____________ (Including this pregnancy if New OB appt)
How many children born alive? _____________
How many stillborn? _____________
How many premature? (prior to 36 wks.) _____________
How many miscarriages? _____________
How many abortions? _____________
How many Cesarean sections? _____________
Any complications in previous pregnancies or deliveries? Y / N
Please explain: ____
____
____

Preg #	Birth Date of Child	M / F	Birth Wt.	Delivery Type	Hospital

SOCIAL HISTORY:

MARITAL STATUS: ○ Married ○ Single ○ Divorced ○ Widowed

OCCUPATION: ____

SMOKING HISTORY ○ current smoker ○ former smoker ○ never smoker

Year Started _______ Cigarettes/day ___________ QUIT when? ________

(Circle) Cigarettes E-Cig Passive Smoke Exposure? Y / N

DRINK ALCOHOL? Y / N Type ____________________ Drinks/day ________

STREET DRUGS? Never / Current / Past Use **<Circle>** Marijuana Meth Cocaine Illicit Rx Crack Heroin

CAFFEINE? Y / N (Circle) Coffee Tea Soda Energy Drinks # drinks/day ________

FORMAL EXERCISE? Y / N Times per week ____________ Type ________________________________

DOMESTIC VIOLENCE HISTORY? Y / N Past / Present Do you feel safe at home? Y / N
SEXUAL ABUSE HISTORY Y / N Past / Present

FAMILY HISTORY: ***STATE IMMEDIATE FAMILY HISTORY OF ILLNESS (living or deceased)**

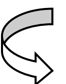
(Circle) Mother: Living / Deceased (age) _______ Father: Living / Deceased (age) _______

M = Mother F = Father MGM = Maternal Grandmother MGF = Maternal Grandfather
Sis = Sister B = Brother PGM = Paternal Grandmother PGF = Paternal Grandfather
MA = Maternal Aunt PA = Paternal Aunt MU = Maternal Uncle PU = Paternal Uncle
D = Daughter Son = Son 0 = Other Family member

Alcoholism	_____________	Heart Disease	_____________
Anesthetic Complications	_____________	Hepatitis	_____________
Anxiety	_____________	High Blood Pressure	_____________
Arthritis	_____________	High Cholesterol	_____________
Asthma	_____________	Kidney Problems	_____________
Bleeding Disorder	_____________	Migraines	_____________
Clotting Disorder	_____________	Osteoporosis	_____________
Depression	_____________	Overweight	_____________
Diabetes	_____________	Seizure Disorder	_____________
Drug Addiction	_____________	Stroke/CVA	_____________
		Thyroid Disorder	_____________

Cancer (please specify type) __________________________

Other ____



Review of Systems

Please circle any of the following symptoms you are experiencing at the present time or check "None of the above".

Constitutional
fatigue
fever
loss of appetite
night sweats
weakness
weight gain or loss
None of the above _______

Allergy
seasonal allergies
None of the above _______

Ophthalmology/Vision
blurring of vision
loss of vision or cataracts
wear glasses or contacts
None of the above _______

Dermatology
acne
dry or sensitive skin
hives, rash or eczema
new or changing lumps
new or changing moles
varicose veins
None of the above _______

ENT
hearing loss
ringing in ears
None of the above _______

Endocrinology
cold intolerance
excessive thirst
heat intolerance
None of the above _______

Cardiology
chest pain
difficulty breathing on exertion
rapid heartbeat
None of the above _______

Respiratory
chronic cough
shortness of breath
wheezing
None of the above _______

Hematology/Lymph
easy bruising
None of the above _______

Musculoskeletal
joint stiffness
leg cramps
joint pain or swelling
None of the above _______

Gastroenterology
abdominal pain
black or blood in stool
constipation
diarrhea
heartburn
nausea
vomiting
None of the above _______

Female Reproductive
abnormal vaginal discharge
decreased libido (sex drive)
painful periods
painful intercourse
frequent yeast infections
heavy periods
hot flashes
infertility
irregular menstrual cycles
pelvic pain
vaginal dryness
None of the above _______

Urology
blood in urine
difficulty urinating
frequent urination
leaking with cough
leaking with urgency
nocturia (voiding at night)
painful urination
wear pad daily
None of the above _______

Neurology
dizziness
headache
memory loss
seizures
tingling/numbness
None of the above _______

Psychology
anxiety
depression
eating disorder
high stress level
mental or physical abuse
severe mood swings
sleep disturbances
suicidal thoughts
None of the above _______

*

Signature/Date ________________________________

* * ***RETURN TO FRONT DESK COMPLETED**