Patient Intake Form

Name: Preferred Name:

Gender Identity: Female Male Transgender Man/Transman Transgender Woman/Transwoman
Genderqueer/Gender Nonconforming Additional Identity _____ Decline to say

Birth Sex: Female Male Decline to say Preferred Pronouns: She/Her/s He/Him/His They/Them

Birthdate: Age:

Reason for Visit Today:

Allergies

Medication Allergy	Reaction

Medications

Name	Dose	Frequency

Social History

Have you ever used tobacco products? Y / N Do you drink alcohol? Y / N
Have you ever used recreational drugs? Y / N Do you currently use? Y / N
How often do you exercise? Rarely 1-2 times/week 3-5 times/week Daily
Physical Abuse? Y / N Sexual Abuse? Y / N Sexual Orientation:
Do you have a living will or advance directive? Y / N Are you an organ donor? Y / N
Are you currently working? Y / N Occupation:

GYN History

First day of last menstrual period: Age of first period: Age at Menopause:
Number of days between periods: Length of periods (days):
Menstrual Flow: Light Moderate Heavy Current Birth Control Method:
Have you ever used birth control pills? Y / N Had an IUD? Y / N Used Depo? Y / N
Date of last pap smear and results: _____
Have you ever had an abnormal pap smear? Y / N IF YES – Date/Result/Treatment: _____
Have you ever had a history of any sexually transmitted diseases? Y / N
If yes, please circle the following that apply: Herpes Gonorrhea Chlamydia Syphilis Trichomonas
Genital Warts Hepatitis B Hepatitis C HIV HPV
Have you ever had problems with infertility? Y/ N Endometriosis? Y / N Fibroids? Y / N
Date of last Mammogram: Date of last Colonoscopy:
Date of last Dexa/Bone Scan: Would you take blood products in an emergency? Y / N

Obstetric History

How many times have you been pregnant? _____

How many children have you had that were full term? (delivered at 37 weeks or more) _____

How many children have you had that were preterm? (delivered before 37 weeks) _____

How many abortions have you had? _____ How many miscarriages/pregnancy losses have you had? _____

Birth Date	Birth Weight	Gender	Weeks Pregnant	Delivery Type	Notes

Past Medical History

Please circle any of the following that you have personally experienced:

Asthma/Emphysema/COPD	High Blood Pressure	High Cholesterol	Diabetes
Heart Attack/Heart Disease	Stroke	Deep Vein Thrombosis	Bleeding Disorder
Problems with Anesthesia	Thyroid Disorder	Stomach Ulcers/Reflux/Gastritis	Cancer:
Anxiety	Depression	Migraines	PCOS

Other:

Surgical History

Date	Surgery	Indication/Reason	Hospital/Surgeon

Family History

Have any of your blood relatives had any of the following conditions? (Please list Relationship)

Uterine Cancer:_____ Ovarian Cancer: _____

Colon Cancer: _____ Breast Cancer: _____

Anesthesia Problems: _____ Bleeding/Clotting Problems: _____

Please list any other medical conditions that affect any of the following family members:

Mother:	Father:
Maternal Aunts:	Paternal Aunts:
Maternal Uncles:	Paternal Uncles:
Maternal Grandmother:	Paternal Grandmother:
Maternal Grandfather:	Paternal Grandfather:
Sisters:	Brothers:
Other Relatives:	

Review Of Systems

Please circle any of the following symptoms you are CURRENTLY experiencing or have experienced within the last 7 DAYS:

General	Skin	HEENT	Lungs
Weight Loss	Rash	Headaches	Shortness of Breath
Weight Gain	Itching	Blurred Vision	Cough
Fatigue	Skin Changes	Hearing Changes	Wheezing
Night Sweats	Mole/Skin Tag Changes	Congestion	Coughing up blood
Fever or Chills			
Gastrointestinal	**Genitourinary**	**Gynecologic**	**Musculoskeletal**
Nausea	Urinary Burning	Heavy Periods	Aching Joints
Vomiting	Urinary Frequency	Painful Periods	Muscle Spasms
Reflux	Urinary Urgency	Irregular Periods	Back Pain
Constipation	Leaking of Urine	Vaginal Discharge	Muscle Aches
Diarrhea	Blood in Urine	Pain w/ Intercourse	Weakness
	Painful Urination		
Psychiatric	**Hematologic**	**Endocrine**	**Immune System**
Anxiety	Easy Bruising	Excessive Thirst	Allergies
Depression	Easy Bleeding	Hot Flashes	Immune Disorder
Panic Attacks	Blood Clots	Heat/Cold Intolerance	
Thoughts of harming self/others	Swollen Glands		
Cardiovascular	**Neurologic**	**Breast**	**Other:**
Chest Pain	Dizziness	Breast Pain	
Racing Heart	Fainting	Nipple Discharge	
Swelling in hands/feet	Trouble Walking	Lumps in Breast	
	Numbness		
	Tingling		