Patient Intake Form

Name:	Birthdate:	Age:

Reason for Visit Today

Allergies

Medication Allergy	Reaction

Medications

If you have more medications to list, please write on back of this page and notify your nurse

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 WEEKLY 3-5 TIMES WEEKLY DAILY
Physical Abuse? Y N Sexual Abuse? Y N Sexual Orientation_____
Living Will or Advanced Directive? Y N Organ Donor? Y N
Are you currently working? Y N Occupation? _____

Gyn History

First day of last menstrual period _____ Age of First Period _____
Number of days between periods _____ Length of periods(days) _____
Periods are **LIGHT MODERATE HEAVY** Method of birth control _____
Have you ever used birth control pills? Y N IUD? Y N Depo? Y N

Have you ever had an abnormal pap? Y N If yes when? _____
When was your last pap smear? _____ Results _____
Any history of sexually transmitted infections? Y N If yes please circle the following that apply
Herpes Gonorrhea Chlamydia Syphilis Trichomonas Genital Warts Hep B Hep C HIV

Last Mammogram _____ Last Colonoscopy _____ Last Bone Scan _____
Have you ever had problems with infertility? Y N Endometriosis? Y N Fibroids? Y N
Would you take blood or 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 pre-term? (delivered before 37 weeks) _____

How many abortions have you had? ____How many miscarriage/pregnancy loss have you had? ___

Birth Date	Birth Weight	Gender	Weeks Preg	Delivery Type	Notes

Past Medical History

Have <u>you</u> ever had any of the following? Please circle <u>all</u> of the following that apply

Asthma/Emphysema/COPD High Blood Pressure Heart Attack/Disease/Stroke

Bleeding or Blood Clotting Problems Problems with Anesthesia Seizures

Stomach Ulcers, Reflux, Gastritis Diabetes

Cancer/Type _____ Other _____

Surgical History

Date	Surgery (Open or Small Incision)	Indication/Reason	Hospital/Surgeon

Family Medical History

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

Uterine Cancer _____	Ovarian Cancer _____
Colon Cancer _____	Breast Cancer _____
Anesthesia Problems _____	Bleeding/Blood clotting problems _____

Please list any other conditions that affect the following family members

Mother	Father
Maternal Aunts	Paternal Aunts
Maternal Uncles	Paternal Uncles
Maternal Grandmother	Paternal Grandmother
Maternal Grandfather	Paternal Grandfather
Siblings	Other Relatives

Please circle any of the following you CURRENTLY have or have occurred in the PAST WEEK				
General	**Skin**	**HEENT**	**Lungs**	**Cardiovascular**
Weight Loss	Rash	Headaches	Cough	Chest Pain
Weight Gain	Itching	Hearing changes	Wheezing	Racing Heart
Fatigue	Skin Changes	Blurry Vision	Shortness of Breath	Swelling in hands or feet
Night Sweats		Congestion	Coughing up blood	
Fever or Chills				
Gastrointestinal	**Genitourinary**	**Gynecologic**	**Musculoskeletal**	**Neurologic**
Nausea or Vomiting	Urinary Burning	Heavy Periods	Aching Joints	Dizziness
Reflux	Frequency	Painful Periods	Muscle Spasms	Fainting
Constipation	Urgency	Irregular Periods	Back Pain	Seizures
Diarrhea	Leaking of urine	Vaginal Discharge	Muscle Aches	Trouble Walking
	Blood in urine	Pain with intercourse	Weakness	Numbness or Tingling
	Painful urination			
Psychiatric	**Hematologic**	**Endocrine**	**Immune System**	**Breast**
Anxiety	Easy Bruising	Excess thirst	Allergies	Breast Pain
Depression	Easy Bleeding	Hot Flashes	Immune Disorder	Nipple Discharge
Thoughts of harming self or others	Blood Clots	Heat or Cold Intolerance		Lumps in Breast
Panic Attacks	Swollen Glands			