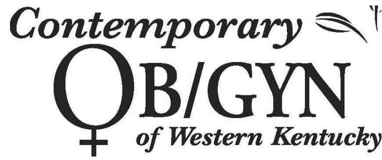

FOR OFFICE USE ONLY
☐ NEW PATIENT
☐ ESTABLISHED PATIENT
☐ CONSULTATION
☐ REPORT SENT. / /

PATIENT INTAKE HISTORY

PATIENT NAME:	BIRTH DATE: / /	SS #:	DATE: / /
ADDRESS			
CITY:	STATE/ZIP:		
HOME TELEPHONE: ( )	WORK TELEPHONE: ( )		
EMPLOYER:	INSURANCE:	POLICY NO.:	
NAME YOU WOULD LIKE US TO USE:	NAME OF SPOUSE/PARTNER:		
NAME OF INSURED:	BIRTH DATE: / /	SS #:	
EMERGENCY CONTACT:	RELATIONSHIP:		
	HOME TELEPHONE: ( )	WORK TELEPHONE: ( )	
PHARMACY LOCAL:	MAIL ORDER:		
WHY HAVE YOU COME TO THE OFFICE TODAY?	REFERRED BY:		
IS THIS A NEW PROBLEM?			
PLEASE DESCRIBE YOUR PROBLEM, INCLUDING WHERE IT IS, HOW SEVERE IT IS, AND HOW LONG IT HAS LASTED.			

GYNECOLOGIC HISTORY

	PHYSICIAN'S NOTES
AGE PERIODS BEGAN: ______ LAST MENSTRUAL PERIOD: ______	
DAYS BETWEEN PERIODS ______ LENGTH OF FLOW ______	
HAVE YOU EVER HAD SEX? ______ ARE YOU CURRENTLY SEXUALLY ACTIVE? ______	
NUMBER OF SEXUAL PARTNERS (LIFETIME): ______	
SEXUAL PARTNERS ARE ☐ MEN ☐ WOMEN ☐ BOTH	
PRESENT METHOD OF BIRTH CONTROL:	
HAVE YOU EVER USED AN INTRAUTERINE DEVICE (IUD) OR BIRTH CONTROL PILLS?	
IF YES, FOR HOW LONG?	
WHEN WAS YOUR LAST PAP TEST? ________ WHAT WAS THE RESULT? ____________	
HAVE YOU EVER HAD AN ABNORMAL PAP TEST?	
DO YOU DO BREAST SELF-EXAMINATIONS?	
HAVE YOU EVER HAD A SEXUALLY TRANSMITTED DISEASE (GONORRHEA, CHLAMYDIA, ETC)?	
WHEN WAS YOUR LAST MAMMOGRAM? ________ HAS IT EVER BEEN ABNORMAL? ______	
WHEN WAS YOUR LAST DEXA OR BONE DENSITY TEST?	
WHEN WAS YOUR LAST COLONOSCOPY?	

PATIENT INTAKE HISTORY *(Continued)*

PATIENT NAME:	BIRTH DATE: / /	SS #:	DATE: / /

OBSTETRIC HISTORY

	NUMBER		NUMBER		NUMBER
PREGNANCIES		ABORTIONS		MISCARRIAGES	
PREMATURE BIRTHS (<37 WEEKS)		LIVE BIRTHS		LIVING CHILDREN	

NO.	BIRTH DATE	WEIGHT AT BIRTH	BABY'S SEX	WEEKS PREGNANT	TYPE OF DELIVERY (VAGINAL, CESAREAN, ETC.)	PHYSICIAN'S NOTES
1.						
2.						
3.						
4.						

ANY PREGNANCY COMPLICATIONS?

☐ DIABETES ☐ HYPERTENSION/HIGH BLOOD PRESSURE ☐ PREECLAMPSIA/TOXEMIA ☐ OTHER

ANY HISTORY OF DEPRESSION BEFORE OR AFTER PREGNANCY? ☐ NO ☐ YES, HOW TREATED

CURRENT MEDICATIONS
(Including hormones, vitamins, herbs, nonprescription medications)

DRUG NAME	DOSAGE	WHO PRESCRIBED	DRUG NAME	DOSAGE	WHO PRESCRIBED

FAMILY HISTORY

MOTHER: ☐ LIVING ☐ DECEASED-CAUSE: AGE: FATHER: ☐ LIVING ☐ DECEASED-CAUSE: AGE:

SIBLINGS: NUMBER LIVING: NUMBER DECEASED: CAUSE(S)/AGE(S):

NUMBER LIVING: NUMBER DECEASED: CAUSE(S)/AGE(S):

ILLNESS	YES	WHICH RELATIVE(S) AND AGE OF ONSET	PHYSICIAN'S NOTES
DIABETES	☐		
STROKE	☐		
HEART DISEASE	☐		
BLOOD CLOTS IN LUNGS OR LEGS	☐		
HIGH BLOOD PRESSURE	☐		
HIGH CHOLESTEROL	☐		
OSTEOPOROSIS (WEAK BONES)	☐		
HEPATITIS	☐		
HIV/AIDS	☐		
TUBERCULOSIS	☐		
BIRTH DEFECTS	☐		
ALCOHOL OR DRUG PROBLEMS	☐		
BREAST CANCER	☐		
COLON CANCER	☐		
OVARIAN CANCER	☐		
UTERINE CANCER	☐		
MENTAL ILLNESS/DEPRESSION	☐		
ALZHEIMER'S DISEASE	☐		
OTHER	☐		

PATIENT INTAKE HISTORY *(Continued)*

PATIENT NAME:	BIRTH DATE: / /	SS #:	DATE: / /

SOCIAL HISTORY

	YES	NO	PHYSICIAN'S NOTES
EVER SMOKED? CURRENT SMOKING: PACKS PER DAY: YEARS:	☐	☐	
ALCOHOL DRINKS PER DAY: DRINKS PER WEEK: TYPE OF DRINK:	☐	☐	
DRUG USE	☐	☐	
SEAT BELT USE	☐	☐	
REGULAR EXERCISE: HOW LONG AND HOW OFTEN?	☐	☐	
DAIRY PRODUCT INTAKE AND/OR CALCIUM SUPPLEMENTS DAILY INTAKE:	☐	☐	
HEALTH HAZARDS AT HOME OR WORK?	☐	☐	
HAVE YOU BEEN SEXUALLY ABUSED, THREATENED, OR HURT BY ANYONE?	☐	☐	
DO YOU HAVE AN ADVANCE DIRECTIVE (LIVING WILL?)	☐	☐	
ARE YOU AN ORGAN DONOR?	☐	☐	

PERSONAL PROFILE

SEXUAL ORIENTATION: ☐ HETEROSEXUAL ☐ HOMOSEXUAL ☐ BISEXUAL
MARITAL STATUS: ☐ MARRIED ☐ LIVING WITH PARTNER ☐ SINGLE ☐ WIDOWED ☐ DIVORCED
NUMBER OF LIVING CHILDREN:
NUMBER OF PEOPLE IN HOUSEHOLD:
SCHOOL COMPLETED: ☐ HIGH SCHOOL ☐ SOME COLLEGE/AA DEGREE ☐ COLLEGE ☐ GRADUATE DEGREE ☐ OTHER
CURRENT OR MOST RECENT JOB:
TRAVEL OUTSIDE THE UNITED STATES: LOCATION(S):

PERSONAL PAST HISTORY OF ILLNESSES/DISEASES

OPERATIONS/HOSPITALIZATIONS

REASON	DATE	HOSPITAL

PATIENT NAME:	BIRTH DATE: / /	SS #:	DATE: / /

REVIEW OF SYSTEMS (ROS)

1. CONSTITUTIONAL	☐ NEGATIVE ☐ WEIGHT LOSS ☐ WEIGHT GAIN ☐ CHANGE IN WEIGHT ☐ FEVER ☐ FATIGUE ☐ OTHER TALLEST HEIGHT ____________
2. EYES	☐ NEGATIVE ☐ VISION CHANGE ☐ GLASSES/CONTACTS ☐ OTHER
3. EAR, NOSE, AND THROAT	☐ NEGATIVE ☐ ULCERS ☐ SINUSES ☐ MOUTH SORES ☐ HEADACHE ☐ HEARING LOSS ☐ OTHER ☐ DENTAL PROBLEMS
4. CARDIOVASCULAR	☐ NEGATIVE ☐ CHEST PAIN ☐ DIFFICULTY BREATHING ON EXERTION ☐ SWELLING IN LEGS ☐ RAPID HEART BEAT ☐ OTHER
5. RESPIRATORY	☐ NEGATIVE ☐ WHEEZING ☐ COUGHING UP BLOOD ☐ SHORTNESS OF BREATH ☐ COUGH ☐ OTHER
6. GASTROINTESTINAL	☐ NEGATIVE ☐ DIARRHEA ☐ BLOODY STOOL ☐ NAUSEA/VOMITING/INDIGESTION ☐ CONSTIPATION ☐ FLATULENCE ☐ PAIN ☐ INVOLUNTARY LOSS OF GAC/STOOL ☐ OTHER
7. GENITOURINARY	☐ NEGATIVE ☐ BLOOD IN URINE ☐ PAINFUL URINATION ☐ URGENCY ☐ FREQUENCY ☐ INCOMPLETE EMPTYING ☐ INCONTINENCE ☐ PAINFUL INTERCOURSE ☐ ABNORMAL OR PAINFUL PERIODS ☐ PMS ☐ ABNORMAL VAGINAL BLEEDING ☐ ABNORMAL VAGINAL DISCHARGE ☐ OTHER
8. MUSCULOSKELETAL	☐ NEGATIVE ☐ MUSCLE WEAKNESS ☐ MUSCLE OR JOINT PAIN ☐ OTHER
9a. SKIN	☐ NEGATIVE ☐ RASH ☐ ULCERS ☐ SKIN CHANGES ☐ DRY SKIN ☐ MOLES ☐ OTHER
9b. BREAST	☐ NEGATIVE ☐ PAIN IN BREAST ☐ DISCHARGE ☐ LUMPS ☐ OTHER
10. NEUROLOGIC	☐ NEGATIVE ☐ PASSING OUT ☐ SEIZURES ☐ NUMBNESS ☐ TROUBLE WALKING ☐ SEVERE MEMORY PROBLEMS ☐ OTHER
11. PSYCHIATRIC	☐ NEGATIVE ☐ DEPRESSION ☐ CRYING ☐ SEVERE ANXIETY ☐ OTHER
12. ENDOCRINE	☐ NEGATIVE ☐ DIABETES ☐ HYPOTHYROID ☐ HYPERTHYROID ☐ HOT FLASHES ☐ HAIR LOSS ☐ HEAT/COLD INTOLERANCE ☐ OTHER
13. HEMATOLOGIC/LYMPHATIC	☐ NEGATIVE ☐ BRUISES ☐ BLEEDING ☐ ENLARGED LYMPH NODES/GLANDS ☐ OTHER
14. ALLERGIC/IMMUNOLOGIC	MEDICATIONS (PLEASE LIST) ☐ LATEX ☐ OTHER