

Patient Name \_\_\_\_\_

DOB \_\_\_\_\_

Today's Date \_\_\_\_\_

**PATIENT INTAKE HISTORY**

<b>AGE:</b> _____		<b>SSN:</b> _____	
<b>PATIENT NAME:</b>		<b>DOB:</b>	
<b>ADDRESS</b>			
<b>CITY</b>		<b>STATE/ZIP</b>	
<b>HOME PHONE</b>		<b>OTHER PHONE</b>	
<b>EMPLOYER</b>		<b>INSURANCE</b>	
<b>INSURANCE ID</b>		<b>POLICY HOLDER NAME/ DOB</b>	
<b>EMERGENCY CONTACT</b>		<b>PHONE</b>	
<b>REFERRED BY</b>			
<b>REASON FOR VISIT</b>			
<b>IS THIS A NEW PROBLEM?</b>			
<b>PLEASE DESCRIBE PROBLEM, INCLUDING WHERE IT IS, SEVERITY, AND HOW LONG YOU HAVE BEEN EXPERIENCING IT?</b>			
<b>PLEASE LIST ANY ALLERGIES</b>			

**GYNECOLOGIC HISTORY**

<b>LAST NORMAL PERIOD</b>	
<b>AGE PERIODS BEGAN</b>	
<b>LENGTH OF PERIOD</b>	
<b>NUMBER OF DAYS BETWEEN PERIODS</b>	
<b>ANY CHANGE IN PERIODS?</b>	
<b>ARE YOU CURRENTLY SEXUALLY ACTIVE?</b>	
<b>HAVE YOU EVER HAD SEX?</b>	
<b>NUMBER OF SEXUAL PARTNERS IN YOUR LIFETIME</b>	
<b>PRESENT METHOD OF BIRTH CONTROL</b>	
<b>PREVIOUS USE OF IUD OR BIRTH CONTROL PILLS</b>	
<b>IF YES, HOW LONG</b>	
<b>WHEN WAS YOUR LAST PAP SMEAR</b>	
<b>WHAT WAS THE RESULT</b>	
<b>HAVE YOU EVER HAD AN ABNORMAL PAP SMEAR</b>	
<b>DO YOU PERFORM SELF BREAST EXAMINATIONS</b>	

**OBSTETRIC HISTORY**

	<b>NUMBER</b>		<b>NUMBER</b>		<b>NUMBER</b>
<b>PREGNANCIES</b>		<b>ABORTIONS</b>		<b>MISCARRIAGES</b>	
<b>PREMATURE BIRTHS</b>		<b>LIVE BIRTHS</b>		<b>LIVING CHILDREN</b>	

	<b>BIRTH DATE</b>	<b>WEIGHT</b>	<b>SEX</b>	<b>WEEKS PREGNANT</b>	<b>DELIVERY TYPE</b>
<b>1</b>					
<b>2</b>					
<b>3</b>					
<b>4</b>					
<b>ANY PREGNANCY COMPLICATIONS</b>					

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**CURRENT MEDICATIONS**

(PLEASE INCLUDE HORMONES, VITAMINS, HERBS, AND NON-PRESCRIPTION MEDICATIONS)

DRUG NAME	DOSAGE	WHO PRESCRIBED	DRUG NAME	DOSAGE	WHO PRESCRIBED

**FAMILY HISTORY**

<b>MOTHER:</b>	<input type="checkbox"/> LIVING	<input type="checkbox"/> DECEASED – CAUSE	AGE
<b>FATHER:</b>	<input type="checkbox"/> LIVING	<input type="checkbox"/> DECEASED – CAUSE	AGE
<b>SIBLINGS:</b>	NUMBER LIVING	NUMBER DECEASED	CAUSES/AGES
<b>CHILDREN:</b>	NUMBER LIVING	NUMBER DECEASED	CAUSES/AGES
<b>DIABETES</b>			
<b>STROKE</b>			
<b>HEART DISEASE</b>			
<b>BLOOD CLOTS LUNGS/LEGS</b>			
<b>HIGH BLOOD PRESSURE</b>			
<b>OSTEOPOROSIS</b>			
<b>HEPATITIS</b>			
<b>HIV/AIDS</b>			
<b>TUBERCULOSIS</b>			
<b>BIRTH DEFECTS</b>			
<b>BREAST CANCER</b>			
<b>COLON CANCER</b>			
<b>OVARIAN CANCER</b>			
<b>ALCOHOL OR DRUG PROBLEMS</b>			
<b>UTERINE CANCER</b>			
<b>MENTAL ILLNESS/ DEPRESSION</b>			
<b>ALZHEIMERS DISEASE</b>			
<b>OTHER</b>			

**SOCIAL HISTORY**

	YES	NO
<b>SMOKING: PACKS PER DAY -</b>		
<b>ALCOHOLIC DRINKS</b>		
<b>DRUG USE</b>		
<b>SEAT BELT USE</b>		
<b>REGULAR EXERCISE</b>		
<b>HEALTH HAZARDS AT HOME OR WORK</b>		
<b>HISTORY OF SEXUAL/PHYSICAL/MENTAL ABUSE</b>		
<b>ARE YOU AN ORGAN DONOR</b>		
<b>DO YOU HAVE AN ADVANCED DIRECTIVE</b>		

**PERSONAL PROFILE**

<b>SEXUAL ORIENTATION</b>	<input type="checkbox"/> HETEROSEXUAL	<input type="checkbox"/> HOMOSEXUAL	<input type="checkbox"/> BISEXUAL
<b>MARITAL STATUS</b>	<input type="checkbox"/> MARRIED	<input type="checkbox"/> SINGLE	<input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
<b>NUMBER OF PEOPLE LIVING IN YOUR HOUSEHOLD</b>			
<b>HIGHEST LEVEL OF EDUCATION</b>			
<b>CURRENT EMPLOYER</b>			
<b>TRAVEL OUTSIDE OF THE USA:</b>	<b>LOCATIONS:</b>		

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**PERSONAL MEDICAL HISTORY**

MAJOR ILLNESS	YES	NO	UNSURE
ANEMIA			
ARTHRITIS			
ASTHMA			
AUTO IMMUNE DISEASE (LUPUS)			
BLEEDING DISORDERS			
BLOOD CLOTS IN LUNGS OR LEGS			
BLOOD TRANSFUSIONS			
BOWEL PROBLEMS			
CANCER			
CATARACTS			
DEPRESSION/ ANXIETY			
DIABETES			
EATING DISORDERS			
FIBROIDS			
GALLBLADDER DISEASE/STONES			
GLAUCOMA			
HEADACHES			
HEART ATTACK/DISEASE			
HEPATITIS			
HIGH BLOOD PRESSURE			
HIV/AIDS			
INFERTILITY			
KIDNEY INFECTIONS/STONES			
LIVER DISEASE			
PNEUMONIA/LUNG DISEASE			
REFLUX/ HIATAL HERNIA			
RHEUMATIC FEVER			
SEXUALLY TRANSMITTED DISEASE			
SIEZURES			
STROKE			
THYROID DISEASE			
TUBERCULOSIS			
OTHER			

**OPERATIONS/ HOSPITALIZATIONS**

REASON	DATES	HOSPITAL

**INJURIES/ ILLNESSES**

TYPE	DATE	TYPE	DATE