Patient Name______________________ DOB_________ Today's Date________

PATIENT INTAKE HISTORY

AGE:_______ SSN:____________________

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

GYNECOLOGIC HISTORY

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

OBSTETRIC HISTORY

	NUMBER		NUMBER		NUMBER
PREGNANCIES		ABORTIONS		MISCARRIAGES	
PREMATURE BIRTHS		LIVE BIRTHS		LIVING CHILDREN	

	BIRTH DATE	WEIGHT	SEX	WEEKS PREGNANT	DELIVERY TYPE
1					
2					
3					
4					
ANY PREGNANCY COMPLICATIONS					

Patient Name______________________ DOB_________ Today's Date________

CURRENT MEDICATIONS

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

DRUG NAME	DOSAGE	WHO PRESCRIBED	DRUG NAME	DOSAGE	WHO PRESCIBED

FAMILY HISTORY

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

SOCIAL HISTORY

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

PERSONAL PROFILE

SEXUAL ORIENTATION	☐ HETEROSEXUAL	☐ HOMOSEXUAL	☐ BISEXUAL	
MARITAL STATUS	☐ MARRIED	☐ SINGLE	☐ WIDOWED	☐ DIVORCED
NUMBER OF PEOPLE LIVING IN YOUR HOUSEHOLD				
HIGHEST LEVEL OF EDUCATION				
CURRENT EMPLOYER				
TRAVEL OUTSIDE OF THE USA:			LOCATIONS:	

Patient Name______________________ DOB_________ Today's Date________

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