New Patient Intake History

Name_____ Age___ D.O.B_____ Date of Appointment_____

Occupation_____ Marital Status: Single:__ Separated:__
Engaged:__ Divorced:__
Married:__ Widowed:__
Gay relationship:__

Referred By: _____ Spouse/Partner's Name: _____

Reason for visit today:_____

Gynecologic History

A. Menstruation

1. Age your periods started_____
2. First day of your last period_____
3. Are your periods regular? Yes___ No___ Length of time from one period to the next_____
4. Do you have pain with your periods? Yes___ No___ If yes, do you take medication?_____

B. Pap Smears

1. When was your last Pap Smear? _____ Result?_____
2. Have you ever had an abnormal pap smear? Yes___ No___ Result? _____ Treatment?_____

C. Contraception

1. Are you sexually active at this time? _____
2. If you are sexually active with a male partner and not attempting pregnancy, what form of birth control do you use? _____
3. Are you experiencing any problems with your current method?_____

4. How long have you been using your current method?
5. Do you wish to continue with your current method?_____ Are you interested in a different method?

D. Gynecologic Infections

1. Do you have a discharge at present? ____ Describe:_____
2. Have you ever been diagnosed and/or treated for any of the following?:

   Gonorrhea____ Syphilis_____ Chlamydia____ Herpes____ HPV/Warts____

   Bacterial Vaginosis (BV)____ Yeast____

E. Menopause or Perimenopause (if applicable)

1. Do you have hot flashes? Yes____ No____
2. Do you have night sweats? Yes___ No____
3. Any other symptoms you believe are menopause related? _____
4. Age your mother/sisters went through menopause, if known _____
5. Are you or have you ever been on any hormone replacement therapy for menopause symptoms? Yes__ No__ Brand or product name_____
   How long have you been on it/were you on it? _____

F. Breasts

1. Have you ever had a mammogram? Yes__ No___ If yes when was the last one? _____ Where was it done?
2. Is there any family history with breast cancer? Yes__ No__ If yes, who? _____
3. Have you ever been diagnosed with a breast condition OTHER than fibrocystic change? Yes__ No__ What was the diagnosis? _____
4. Have you been told you have fibrocystic breasts? Yes___ No___
5. Do you perform self breast exams? Yes__ No__

Obstetric History

Have you been pregnant before? Yes___ No___

How many times? _____ Number of full term pregnancies_____

Preterm Pregnancies____ Miscarriages_____ Abortions_____ Ectopic(tubal) pregnancies_____

Number of living children_____

Deliveries

Month/Year	Baby's birth weight	Baby's gender	Vaginal birth or C-Section	Complications

Medical History	*You*	*Family Member*
(Check "yes" to any that apply)		
Headaches	___	___
Psychiatric Disorder, including depression	___	___
Neurologic Condition	___	___
Thyroid problems	___	___
Heart Condition	___	___
High Blood Pressure	___	___
Asthma or other lung condition	___	___
Liver problems, including hepatitis	___	___
Digestive, stomach, bowel or gallbladder problems	___	___
Kidney or bladder problems	___	___
Anemia or blood disorders	___	___
Blood transfusion	___	___
Diabetes	___	___
Cancer	___	___
Birth defects or other inherited diseases	___	___
Other medical problems	___	___

Surgical History

Please list every operation, including Cesarean sections and plastic surgery such as breast implants

Month/Year	Operation	Complications

Medications

Please list here all prescription and over-the-counter medications

Drug	Dosage	Schedule(frequency)	Reason/Disease

Please list here any herbal or botanical preparations

Herb/Botanical product	Dosage	Schedule(frequency)	Reason/Disease

Allergies

Please list any allergic reactions you have experienced

Drug	Reaction

Smoking

Yes___ How many cigarette or packs a day? _____
No, never____ No, quit_____

Alcohol

Yes___ How many drinks per day, week, or month?_____ What type? (Beer, wine, cocktails) _____
No____

Recreational drugs?
Such as marijuana, cocaine, etc?

Other medical history not previously described? :

For Office Use Only

Ht:

Wt:

BP:

Notes: