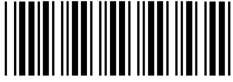

Washington University in St. Louis Physicians

Minimally Invasive Gynecologic Surgery Intake Form

Visit Date____ /____ / __________

PATIENT INFORMATION

Name: Last _________________________ First__________________ MI_____ Preferred name __________________

Gender identity: ☐ Female ☐ Male ☐ Other (specify) _______________ Date of birth____ /____ / ______ Age____

Referred by (physician's name)____

Reason for visit ____

____

____

MEDICAL PROBLEMS Please check Y (Yes) or N (No) for each

☐ Y ☐ N High blood pressure	☐ Y ☐ N Diabetes	☐ Y ☐ N Prior abdominal mesh
☐ Y ☐ N Migraines	☐ Y ☐ N Cancer type ________________	☐ Y ☐ N Diverticulitis
☐ Y ☐ N High cholesterol		☐ Y ☐ N Lupus
☐ Y ☐ N Blood clot to leg/lung	☐ Y ☐ N Seizures	☐ Y ☐ N Asthma
☐ Y ☐ N Heart arrhythmia	☐ Y ☐ N Liver/Gallbladder disease	☐ Y ☐ N Other ________________
☐ Y ☐ N CVA/TIA/Stroke	☐ Y ☐ N Ulcers/Reflux	________________

SURGICAL HISTORY

Year	Type of Surgery/Reason For Surgery	Year	Type of Surgery/Reason For Surgery

ALLERGIES

Allergen	Reaction	Allergen	Reaction

PREGNANCY SUMMARY

Total # of pregnancies	Full term	Premature	Miscarriages(s)	Abortions	# of children
# of Vaginal deliveries	# of C-section deliveries	# of Ectopic (tubal)			

GYNECOLOGIC HISTORY Skip questions that do not apply

Age of first period:____________years old

Days between cycles:________ Days of bleeding_________

Last menstrual period (first day)_____ /_____ /______

Number of pads or tampons used per day_________

Do you have pain with periods? ☐ Yes ☐ No ____

When was your last Pap smear? (month) _______ / (year) _________ ☐ Normal ☐ Abnormal

When was your last abnormal Pap smear? (month)________ / (year)__________ ☐ Not applicable

Did you have any of the following for an abnormal Pap smear? ☐ Yes (check all that apply) ☐ No treatment required

☐ Colposcopy– year_________ ☐ LEEP/Laser/Conization– year_________ ☐ Cryosurgery– year_________

Have Pap smears been normal since treatment? ____☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No ☐ n/a Current partners: ☐ Male ☐ Female ☐ Both ☐ Other ☐ n/a

Have you had a new partner within the last 6 months? ☐ Yes ☐ No ☐ n/a

Current method of birth control ____________________________ Consistent use? ☐ Yes ☐ No

Date of last use______ /_______ /_______________ How long has this method been used? _________________

Infection History ☐ None ☐ Chlamydia ☐ Gonorrhea ☐ Genital Herpes ☐ Trichomoniasis ☐ Syphilis ☐ HIV/AIDS ☐ Genital warts/HPV ☐ Pelvic Inflammatory disease ☐ Other ____________________

Preventive Care

Have you ever had a mammogram? ☐ Yes– date ___________ ☐ No ☐ n/a ☐ Normal ☐ Abnormal

Have you ever had a colonoscopy? ☐ Yes– date ___________ ☐ No ☐ n/a ☐ Normal ☐ Abnormal

CURRENT MEDICATIONS Include prescribed, over-the-counter drugs, folic acid or vitamins, herbal remedies or supplements, inhalers, etc.

Pharmacy name		Pharmacy phone	
Name of Medication	**Strength/Dose**	**Frequency Taken**	**Reason for Taking**

FAMILY HISTORY If yes, indicate relationship to you (e.g., maternal aunt)

Blood clotting disorder? . . . . ☐ No ☐ Yes ______

Endometriosis? . . . . ☐ No ☐ Yes ______

Maternal relatives with breast, ovarian, uterine, or colon cancer? . . . ☐ No ☐ Yes ______

SOCIAL HISTORY

Marital status:. . . . . ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Highest education completed: . . ☐ High School ☐ College ☐ Graduate degree ☐ Other ______

Current or most recent job ______

Do you smoke cigarettes? . . . . . . ☐ Yes Cigarettes/day ______ Number of years ______ ☐ Quit– year ______ ☐ No

Do you drink alcohol? . . . . ☐ Yes Drinks/day ______ Drinks/week ______ ☐ No

Do you use marijuana, cocaine, or any other similar drug? . . . . . . ☐ Yes Describe ______ ☐ No

Do you exercise regularly?. . . . . . ☐ Yes Hours/week: Moderate (walking, yoga)______ Vigorous (running) ______ ☐ No

Do you feel safe in your own home? . . . . ☐ Yes ☐ No– explain ______

Do you have any history of physical, emotional, sexual abuse?. . . . . . . ☐ Yes– type ______ ☐ No

Number of people in household ______ Do you wear a seatbelt? ☐ Yes ☐ No

REVIEW OF SYSTEMS Please indicate any symptoms in the last 30 days AND/OR any symptoms currently

☐ Y ☐ N Generally healthy
☐ Y ☐ N Recent weight gain or loss
☐ Y ☐ N Fatigue

☐ Y ☐ N Vision changes
☐ Y ☐ N Sinus problems

☐ Y ☐ N Chest pain
☐ Y ☐ N Irregular heartbeat
☐ Y ☐ N Swelling of legs/ankles/feet
☐ Y ☐ N Bruise/bleed easily

☐ Y ☐ N Loss of urine w/laugh or cough
☐ Y ☐ N Incontinence (leaking) when ______
☐ Y ☐ N Frequent urination
☐ Y ☐ N Pain/Burning w/urination
☐ Y ☐ N Blood in urine

☐ Y ☐ N Extremely painful periods
☐ Y ☐ N Abnormal vaginal discharge
☐ Y ☐ N Irregular vaginal bleeding
☐ Y ☐ N Pelvic pain
☐ Y ☐ N Painful intercourse

☐ Y ☐ N Breast lumps
☐ Y ☐ N Breast pain
☐ Y ☐ N Nipple discharge

☐ Y ☐ N Joint/Muscle pain
☐ Y ☐ N Muscle weakness
☐ Y ☐ N Rashes/Hives
☐ Y ☐ N Acne
☐ Y ☐ N Hair loss or excess hair

☐ Y ☐ N Headaches
☐ Y ☐ N Dizziness

☐ Y ☐ N Nausea/Vomiting
☐ Y ☐ N Heartburn/Reflux
☐ Y ☐ N Abdominal pain
☐ Y ☐ N Diarrhea
☐ Y ☐ N Constipation
☐ Y ☐ N Blood in stools
☐ Y ☐ N Painful bowel movement with menses

☐ Y ☐ N Depression
☐ Y ☐ N Anxiety

☐ Y ☐ N Hot flashes/ Night sweats
☐ Y ☐ N Heat/Cold intolerance
☐ Y ☐ N Excessive hunger/thirst
☐ Y ☐ N Bulge in vagina with straining

☐ Y ☐ N Shortness of breath

OFFICE USE ONLY ☐all other systems negative