Obstetrics & Gynecology Intake form

Visit Date: ____________________

PATIENT INFORMATION			
Patient name *(last, first, M.I):*		**Preferred Name:**	
Gender Identity: ☐ Female ☐ Male ☐ Other: (specify)		**Date of birth:**	**Age:**
Sex at birth: ☐ Female ☐ Male ☐ Intersex		**Pronouns:** ☐ she/her ☐ he/him ☐ Other:	
Reason for visit:			

ALLERGIES	
Allergy:	Reaction:
Allergy:	Reaction:

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

Name of medication	strength/dose	Frequency taken	Reason for taking

MEDICAL PROBLEMS					
☐ Yes ☐ No	**High blood pressure**	☐ Yes ☐ No	**Heart disease (MI)**	☐ Yes ☐ No	**Seizures**
☐ Yes ☐ No	**Migraines**	☐ Yes ☐ No	**CVA/TIA/Stroke**	☐ Yes ☐ No	**Liver/Gall bladder disease**
☐ Yes ☐ No	**High cholesterol**	☐ Yes ☐ No	**Diabetes**	☐ Yes ☐ No	**Ulcers**
☐ Yes ☐ No	**Blood clotting**	☐ Yes ☐ No	**Cancer**	☐ Yes ☐ No	**Other:**

SURGICAL HISTORY

Year	Type of surgery	Reason for surgery

FAMILY HISTORY	
Family history of major illnesses? *(mother, father, siblings)*	☐ Yes ☐ No
Maternal relatives with breast, ovarian, uterine, or colon cancer? *(aunts, grandmother)*	☐ Yes ☐ No

SOCIAL HISTORY

Do you smoke cigarettes? ☐ Yes - How many/day? How many years? ☐ Quit, year: ☐ No

Do you drink alcohol? ☐ Yes - How many/day? How many/week? ☐ No

Do you use marijuana, cocaine, or any other similar drug? ☐ Yes - describe ☐ No

Exercise regularly? ☐ Yes, *How many 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 emotional, physical, sexual abuse? ☐ Yes - *type?* ☐ No

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Number of people in household: | **Do you wear a seatbelt?** ☐ Yes ☐ No

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

Current or most recent job:

NATIONAL LEADERS IN MEDICINE

PREGNANCY SUMMARY

TOTAL PREGNANCIES ____ FULL TERM ____ PREMATURE ____ MISCARRIAGES ____ ABORTIONS ____ # OF CHILDREN ___

(Please list all pregnancies in order, including miscarriages, premature births, stillbirths, ectopics (tubal), and abortions)

Year	Pregnancy outcome (e.g. vaginal delivery, c-section, miscarriage, abortion)	Length of Pregnancy (wk/mo)	Weight	Sex	Problems/Complications (e.g. preterm labor, high blood pressure, diabetes, blood transfusion, infection)
				☐ Boy ☐ Girl	
				☐ Boy ☐ Girl	
				☐ Boy ☐ Girl	
				☐ Boy ☐ Girl	

GYNECOLOGIC HISTORY *(skip questions that do not apply)*

Age when you had your first period: years old	Menstrual periods: ☐ Regular ☐ Irregular
Last menstrual period (first day): / /	Flow (check one): ☐ Light ☐ Moderate ☐ Heavy
Days between cycles: Days of bleeding:	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
Have you needed 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:)	
Pap spears 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	
Date of last intercourse: / /	Condom used? ☐ Yes ☐ No
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 bone density scan?	☐ Yes - date:	☐ No ☐ n/a	☐ Normal ☐ Abnormal
Have you ever had a colonoscopy?	☐ Yes - date:	☐ No ☐ n/a	☐ Normal ☐ Abnormal
Have you received the HPV vaccine? ☐ Yes ☐ No	Shots received (choose one) ☐ 1 ☐ 2 ☐ 3		

REVIEW OF SYSTEMS

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

	Symptom		Symptom		Symptom
☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	Generally Healthy Recent weight gain or loss Fatigue	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	Extremely painful periods Abnormal vaginal dis-charge Irregular vaginal bleeding Pelvic Pain Painful intercourse	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	Nausea/Vomiting Heartburn/reflux Abdominal pain Diarrhea Constipation Blood in Stools
☐ Yes ☐ No ☐ Yes ☐ No	Vision changes Sinus problems				
☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	Chest Pain Irregular heart beat Swelling of legs/ankles/feet Bruise/bleed easily	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	Breast lumps Breast pain Nipple discharge	☐ Yes ☐ No ☐ Yes ☐ No	Depression Anxiety
☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	Frequent urination Pain/Burning w/ urination Incontinence (leaking) Blood in urine	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	Joint/muscle pain Muscle weakness Rashes/Hives Acne Hair loss or excess hair	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	Hot flashes/Night sweats Heat/cold intolerance Excessive hunger/thirst
		☐ Yes ☐ No ☐ Yes ☐ No	Headaches Dizziness	☐ Yes ☐ No	Shortness of Breath

office use only

☐ all other systems negative