Division of **Pediatric, Adolescent, & Young Adults** Gynecology
History Intake Form – New Visit / First Clinic Visit

Date: ___________ Patient Name: ___________________________ DOB: _________ Age: _____

Gender Identity: ☐ Female ☐ Male ☐ Non-binary ☐ Other: ____________________________
Sex assigned at birth: ☐ Female ☐ Male
Preferred pronouns: ☐ She/Her ☐ He/Him ☐ They/them ☐ Other: _____________________

Primary Care Provider:____

Were you referred? ☐ Yes ☐ No If yes, by:____

**_Patient_ phone number:* ______________________________ Can we leave a message? ☐ Yes ☐ No
Guardian phone ____ Relationship___________

Reason for Today's Visit:

I am here to discuss the following problems:

Have you started your periods? ☐ Yes ☐ No

What was the ***first* day** of your last period?

My period comes every ___ - ___ days and lasts ___ - ___ days, I usually change a pad/tampon every _____ hours on the heaviest day of my period.

Have you ever had sex? ☐ Yes ☐ No
Have you ever been pregnant? ☐ Yes ☐ No
Current partners: ☐ Male ☐ Female ☐ Both ☐ other
New partner in last 12 months? ☐ Yes ☐ No
Date of last intercourse:

Have you received the HPV vaccine?
☐ Yes ☐ No
If yes, shots received (choose one):
☐ 1 ☐ 2 ☐ 3
Have you ever had a gynecologic exam before?
☐ Yes ☐ No

Medications: (Please list all current medications, **including birth control**)

<u>Current</u> Medical Conditions:

Have you ever had: Migraine headache with aura? ☐ Yes ☐ No High blood pressure? ☐ Yes ☐ No
Stroke/blood clot or bleeding disorder? ☐ Yes ☐ No Gall bladder disease? ☐ Yes ☐ No
Seizures? ☐ Yes ☐ No

<u>Past</u> Medical conditions:

List Surgical Procedures/Dates:

Allergic to any drugs? ☐ Yes ☐ No
If yes, please list:

FAMILY HISTORY:

Illness	Yes	Relative	Illness	Yes	Relative
Breast Cancer	☐		Heart disease/Stroke	☐	
Uterine Cancer	☐		High blood pressure	☐	
Ovarian Cancer	☐		High Cholesterol	☐	
Other Cancers (list)	☐		Bleeding disorder	☐	
****Venous Thromboembolism (ex: blood clots in lungs, legs, arm)****				☐	
Ovarian Cysts:	☐		Thyroid/ Adrenal Disorder	☐	
Endometriosis	☐		Diabetes	☐	
Menstrual Difficulties (Explain)	☐		Other (list)	☐	

SOCIAL HISTORY:		
Cigarettes	☐ Yes ☐ No	Packs per day: # of years: Year quit:
Alcohol	☐ Yes ☐ No	Drinks per day: Per week:
Drug use (nonprescription)	☐ Yes ☐ No	Type(s):
Seat belt use	☐ Yes ☐ No	
Regular exercise	☐ Yes ☐ No	Type(s):
Hobbies/Activities:		
Who do you live with?		
Do you feel safe at home?		
School completed: ☐ Grade school___ ☐ High School ___ ☐ College ___ ☐ Other ___		
Current Job or Occupations:		

Please **X** to the left of any symptom you are ***currently having***, or mark none.

GENERAL	GASTROINTESTINAL	ENDOCRINE
☐ **NONE**	☐ **NONE**	☐ **NONE**
☐ Weight loss	☐ Nausea/vomiting	☐ Heat / Cold Intolerance
☐ Weight gain	☐ Diarrhea	☐ Brittle hair / nails
☐ Changes in appetite/eating	☐ Constipation	☐ Excessive thirst
☐ Fever	☐ Abdominal pain	☐ Excessive body hair
☐ Fatigue	☐ Rectal bleeding	☐ Hot flushes
EYES/EARS/NOSE/THROAT	**BREASTS**	**GENITAL**
☐ **NONE**	☐ **NONE**	☐ **NONE**
☐ Vision Changes	☐ Breast mass/lump	☐ Irregular menstrual bleeding
☐ Hearing loss	☐ Breast pain	☐ Heavy menstrual bleeding
☐ Inability to smell	☐ Nipple discharge	☐ Menstrual cramping
☐ Difficulty swallowing	**SKIN**	☐ Abnormal vaginal discharge
☐ Dental problems	☐ **NONE**	☐ Vaginal itching/irritation
CARDIOVASCULAR	☐ Rashes/hives	☐ Painful intercourse (sex)
☐ **NONE**	☐ Skin lesions	**URINARY**
☐ Chest pain	☐ Acne	☐ **NONE**
☐ Palpitations	**MUSCULOSKELETAL**	☐ Pain on urination
☐ Irregular heart beat	☐ **NONE**	☐ Urgency (have to pee now)
☐ Lightheaded	☐ Muscle weakness	☐ Involuntary loss of urine (leaking)
☐ Syncope (passing out)	☐ Joint pain	☐ Hesitancy (hard to start stream)
HEMATOLOGIC/LYMPHATIC	☐ Arthritis	☐ Frequent urinary tract infections
☐ **NONE**	**NEUROLOGICAL**	☐ Frequency (Need to pee often)
☐ Enlarged lymph nodes	☐ **NONE**	☐ Blood in urine
☐ Bruise easily	☐ Dizziness	**PSYCHIATRIC**
☐ Blood clot of the arm / leg / lungs	☐ Non-migraine headache	☐ **NONE**
☐ Excessive bleeding following surgery or minor injury	☐ Migraine headache (with aura / without aura)	☐ Cutting or other self-harm behaviors
RESPIRATORY		☐ Depression
☐ **NONE**		☐ Anxiety
☐ Wheezing		☐ Suicidal thoughts or acts
☐ Shortness of breath		☐ Episodes of binging or purging
☐ Chronic cough		☐ Psychiatric hospitalization history

Where do you want your prescriptions to go today?

Pharmacy Name/Number: ____