

PATIENT INTAKE HISTORY

PATIENT NAME: _____ BIRTH DATE: ___/___/___ ID NO: _____ DATE: ___/___/___

WHY HAVE YOU COME TO THE OFFICE TODAY? _____

IS THIS A NEW PROBLEM? _____

DESCRIBE YOUR PROBLEM, INCLUDING WHERE IT IS, HOW SEVERE IT IS AND HOW LONG IT HAS LASTED: _____

IF YOU ARE UNCOMFORTABLE ANSWERING ANY QUESTIONS, LEAVE THEM BLANK; YOU CAN DISCUSS THEM WITH YOUR DOCTOR OR NURSE.

FAMILY HISTORY

GYNECOLOGIC HISTORY

FATHER: LIVING DECEASED – CAUSE ___AGE: ___ LAST NORMAL MENSTRUAL PERIOD (FIRST DAY) ___/___/___

MOTHER: LIVING DECEASED – CAUSE ___AGE: ___ AGE PERIODS BEGAN: _____

SIBLINGS: NUMBER LIVING: ___NUMBER DECEASED: ___ LENGTH OF PERIODS (NUMBER OF DAYS OF BLEEDING): _____

CHILDREN NUMBER LIVING: ___NUMBER DECEASED: ___ NUMBER OF DAYS BETWEEN PERIODS: _____

ILLNESS **YES** WHICH RELATIVE(S) AND AGE OF ONSET ANY RECENT CHANGES IN PERIODS: _____

DIABETES _____ ARE YOU CURRENTLY SEXUALLY ACTIVE? _____

STROKE _____ HAVE YOU EVER HAD SEX? _____

HEART DISEASE _____ NUMBER OF SEXUAL PARTNERS (LIFETIME) _____

BLOOD CLOTS IN LUNGS OR LEGS _____ SEXUAL PARTNERS ARE: MEN WOMEN BOTH

HIGH BLOOD PRESSURE _____ PRESENT METHOD OF BIRTH CONTROL: _____

HIGH CHOLESTROL _____ HAVE YOU EVER USED AN INTRAUTERINE DEVICE

OSTEOPOROSIS _____ (IUD) OR BIRTH CONTROL PILLS? _____

HEPATITIS _____ IF YES, FOR HOW LONG? _____

HIV/AIDS _____ WHEN WAS YOUR LAST PAP TESTS? _____

TUBERCULOSIS _____ WHAT WAS THE RESULT? _____

BIRTH DEFECTS _____ HAVE YOU EVER HAD AN ABNORMAL PAP TEST? _____

ALCOHOL OR DRUG PROBLEMS _____ DO YOU DO BREAST SELF-EXAMINATIONS? _____

BREAST CANCER _____ HAVE YOU BEEN EXPOSED TO DIETHYLSTILBESTROL (DES)? ___

COLON CANCER _____ DATE OF LAST MAMOGRAM: _____RESULTS: _____

OVARIAN CANCER _____ **ALLERGIES: (LIST ANY ALLERGIES THAT YOU HAVE)**

UTERINE CANCER _____

MENTAL ILLNESS/DEPRESSION _____

ALZHEIMER'S DISEASE _____

OTHER _____

LIST ALLERGIES AND REACTIONS BELOW

PATIENT SIGNATURE: _____

DATE: _____

PATIENT INTAKE HISTORY (Continued)

PATIENT NAME: _____ **BIRTH DATE:** __/__/__ **ID NO:** _____ **DATE:** __/__/__

OBSETRIC HISTORY

NUMBER OF:

PREGNANCIES _____ ABORTIONS _____ MISCARRIAGES _____

PREMATURE BIRTHS (<37 WEEKS) __ LIVE BIRTHS _____ LIVING CHILDREN _____

| NO. | BIRTH DATE | WEIGHT AT BIRTH | BABY'S SEX | WEEKS PREGNANT | TYPE OF DELIVERY (VAGINAL, CESAREAN, ETS.) | PHYSICIAN'S NOTES |
|-----|----------------|-----------------|------------|----------------|--|-------------------|
| 1. | ____/____/____ | ____/____ | ____ | ____ | ____ | ____ |
| 2. | ____/____/____ | ____/____ | ____ | ____ | ____ | ____ |
| 3. | ____/____/____ | ____/____ | ____ | ____ | ____ | ____ |
| 4. | ____/____/____ | ____/____ | ____ | ____ | ____ | ____ |
| 5. | ____/____/____ | ____/____ | ____ | ____ | ____ | ____ |

ANY PREGNANCY COMPLICATIONS? _____

DIABETES HYPERTENSION/HIGH BLOOD PRESSURE PREECLAMPSIA/TOSEMIA OTHER _____

ANY HISTORY OF DEPRESSION BEFORE OR AFTER PREGNANCY? _____

CURRENT MEDICATIONS

(Including hormones, vitamins, herbs, nonprescription medications)

| DRUG NAME | DOSAGE | WHO PRESCRIBED | DRUG NAME | DOSAGE | WHO PRESCRIBED |
|----------------|-----------|----------------|----------------|-----------|----------------|
| ____/____/____ | ____/____ | ____ | ____/____/____ | ____/____ | ____ |
| ____/____/____ | ____/____ | ____ | ____/____/____ | ____/____ | ____ |
| ____/____/____ | ____/____ | ____ | ____/____/____ | ____/____ | ____ |
| ____/____/____ | ____/____ | ____ | ____/____/____ | ____/____ | ____ |
| ____/____/____ | ____/____ | ____ | ____/____/____ | ____/____ | ____ |

SOCIAL HISTORY

EVER SMOKED? YES ___ NO _____ CURRENT SMOKING: PACKS PER DAY: _____ YEARS: _____

ALCOHOL: DRINKS PER DAY: _____ DRINKS PER WEEK: _____ TYPE OF DRINK: _____

DRUG USE: YES ___ NO _____ IF SO, TYPE(S) _____

SEAT BELT USE: YES ___ NO _____

REGULAR EXERCISE: HOW LONG AND HOW OFTEN? _____

DAIRY PRODUCT INTAKE AND/OR CALCIUM SUPPLIMENTS: DAILY INTAKE: _____

HEALTH HAZARDS AT HOME OR WORK? _____

HAVE YOU BEEN SEXUALLY ABUSED, THREATENED, OR HURT BY ANYONE? _____

PATIENT SIGNATURE: _____

DATE: _____

PATIENT INTAKE HISTORY (Continued)

PATIENT NAME: _____ **BIRTH DATE:** __/__/__ **ID NO:** _____ **DATE:** __/__/__

PERSONAL PAST HISTORY

| MAJOR ILLNESS | YES (DATE) | NO | NOT SURE |
|--|-----------------------|-----------|-----------------|
| GALLBLADDER DISEASE | _____ / _____ / _____ | | |
| HEADACHES | _____ / _____ / _____ | | |
| INFERTILITY | _____ / _____ / _____ | | |
| BLEEDING DISORDER | _____ / _____ / _____ | | |
| ASTHMA | _____ / _____ / _____ | | |
| PNEUMONIA/LUNG DISEASE | _____ / _____ / _____ | | |
| KIDNEY INFECTIONS/STONES | _____ / _____ / _____ | | |
| TUBERCULOSIS | _____ / _____ / _____ | | |
| FIBROIDS | _____ / _____ / _____ | | |
| SEXUALLY TRANSMITTED DISEASE/CHLAMYDIA | _____ / _____ / _____ | | |
| HIV / AIDS | _____ / _____ / _____ | | |
| HEART ATTACK/DISEASE | _____ / _____ / _____ | | |
| DIABETES | _____ / _____ / _____ | | |
| HIGH BLOOD PRESSURE | _____ / _____ / _____ | | |
| STROKE | _____ / _____ / _____ | | |
| RHEUMATIC FEVER | _____ / _____ / _____ | | |
| BLOOD CLOTS IN LUNGS ORLEGS | _____ / _____ / _____ | | |
| EATING DISORDERS | _____ / _____ / _____ | | |
| AUTOIMMUNE DISEASE | _____ / _____ / _____ | | |
| CHICKENPOX | _____ / _____ / _____ | | |
| CANCER | _____ / _____ / _____ | | |
| THYROID DISEASE | _____ / _____ / _____ | | |
| HEPATITIS/YELLOW JANDICE/LIVER DISEASE | _____ / _____ / _____ | | |
| REFLUX/HIATAL HERNIA/ULCERS | _____ / _____ / _____ | | |
| BROKEN BONES | _____ / _____ / _____ | | |
| ANEMIA | _____ / _____ / _____ | | |
| DEPRESSION/ANXIETY | _____ / _____ / _____ | | |
| ARTHRITIS/JOINT PAIN/BACK PROBLEMS | _____ / _____ / _____ | | |
| CATARACTS | _____ / _____ / _____ | | |
| GLAUCOMA | _____ / _____ / _____ | | |
| BLOOD TRANSFUSIONS | _____ / _____ / _____ | | |
| SEIZURES/CONVULSIONS/EPILEPSY | _____ / _____ / _____ | | |
| BOWEL PROBLEMS | _____ / _____ / _____ | | |
| OTHER: _____ | _____ / _____ / _____ | | |
| OTHER: _____ | _____ / _____ / _____ | | |

PATIENT SIGNATURE: _____

DATE: _____

PATIENT INTAKE HISTORY (Continued)

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REVIEW OF SYSTEMS

Please check (X) if any of the following symptoms apply to you now or since adulthood

- 1. CONSTITUTIONAL
WEIGHT LOSS
WEIGHT GAIN
FEVER
FATIGUE
CHANGE IN HEIGHT

- 2. EAR, NOSE AND THROAT
EARACHES
RINGING IN EARS
HEARING PROBLEMS
SINUS PROBLEMS
SORE THROAT
MOUTH SORES
DENTAL PROBLEMS

- 3. CARDIOVASCULAR
CHEST PAIN OR PRESSURE
DIFICULTY BREATHING ON EXERTION
SWELLING OF LEGS
RAPID OR IRREGULAR HEARTBEAT

- 4. RESPIRATORY
PAINFUL BREATING
WHEEZING
SPITTING UP BLOOD
SHORTNESS OF BREATH

- 5. MUSCULOSKELETAL
MUSCLE WEAKNESS

- 6. NEUROLOGIC
DIZZINESS
SEIZURES
NUMBNESS
TROUBLE WALKING
MEMORY PROBLEMS
FREQUENT HEADACHES

- 7. PSYCHIATRIC
DEPRESSION OR FREQUENT CRYING
ANXIETY

- 8. HEMATOLOGIC/LYMPHATIC
FREQUENT BRUISES
CUTS DO NOT STOP BLEEDING
ENLARGED LYMPH NODES (GLANDS)
OTHER ALLERGIES

- 9. EYES
DOUBLE VISION
SPOTS BEFORE EYES
VISION CHANGES
GLASSES/CONTACTS

- 10. GASTROINTESTINAL
FREQUENT DIARRHEA
BLOODY STOOL
NAUSEA/VOMITING/INDEGESTION
CONSTIPATION
INVOLUNTARY LOSS OF GAS OR STOOL

- 11. GENITOURINARY
BLOOD IN URINE
PAIN WITH URINATION
STRONG URGENCY TO URINATE
FREQUENT URINATION
INCOMPLETE EMPTYING
INVOLUNTARY/UNINTENDED URINE LOSS
URINE LOSS WHEN COUGHING OR LIFTING
ABNORMAL BLEEDING
PAINFUL PERIODS

- 12a. SKIN
RASH
SORES
DRY SKIN
MOLES (GROWTH/CHANGE)

- 12b. BREASTS
PAIN IN BREAST
NIPPLE DISCHARGE
LUMPS

- 13. ENDOCRINE
HAIR LOSS
HEAT/COLD INTOLERANCE
HOT FLASHES

- 14. ALLERGIC/IMMUNOLOGIC
MEDICATION ALLERGIES
LATEX ALLERGY

PLEASE LIST ANY ALLERGY AND TYPE OF REACTION ON PAGE 1

PATIENT SIGNATURE: _____ DATE: _____

PATIENT INTAKE HISTORY (Continued)

PATIENT NAME: _____ **BIRTH DATE:** __/__/__ **ID NO:** _____ **DATE:** __/__/__

OPERATIONS/HOSPITALIZATIONS

| REASON | DATE | HOSPITAL | INJURIES/ILLNESSES | DATE |
|---------------|-------------|-----------------|---------------------------|-------------|
| _____ | / | / | _____ | / |
| _____ | / | / | _____ | / |
| _____ | / | / | _____ | / |
| _____ | / | / | _____ | / |
| _____ | / | / | _____ | / |
| _____ | / | / | _____ | / |
| _____ | / | / | _____ | / |
| _____ | / | / | _____ | / |
| _____ | / | / | _____ | / |

IMMUNIZATIONS/TESTS

| | DATE | | DATE |
|-------------------------------------|-------------|------------------------------------|-------------|
| TETNAS-PIPHTERIA BOOSTER | _____ | INFLUENZAVACCINE (FLU SHOT) | _____ |
| HEPATITIS A VACCINE | _____ | HEPATITIS B VACCINE | _____ |
| VARICELLA (CHICKENPOX)VACCINE | _____ | PNEUMOCOCCAL (PNEUMONIA) | _____ |
| MEASLES-MUMPS-RUBELLA (MMR) VACCINE | _____ | TUBERCULOSIS (TB) SKIN TEST RESULT | ____ |

PATIENT SIGNATURE: _____

DATE: _____