PATIENT INTAKE HISTORY		
Patient Name:	DOB:	Date:
Address:		
City:	State/Zip:	
Home Telephone:	Work Telephone:	
Employer:		
Emergency Contact:	Relationship:	
	Address:	
	Phone:	
Referred By:		
Reason for Visit:		
Is this a new problem?		
Please Describe the Problem:		

If you are uncomfortable answering any questions, leave them blank; you can discuss them with the doctor.

GYNECOLOGIC HISTORY	
First Day of Last Menstrual Period:	Age Periods Began:
Length of Periods:	Number of Days Between Periods:
Any Recent Changes In Periods?	Are You Currently Sexually Active?
Age of First Sexual Intercourse:	Number of Lifetime Sexual Partners:
Date of Last Pap?	What Was the Result?
Ever Had an Abnormal Pap?	Do You Perform Self Breast Exams?
Date of Last Mammogram:	What Was the Result?
Number of Pregnancies:	Number of Deliveries:
Number of Induced Abortions:	Number of Miscarriages:
Current Method of Birth Control:	Are You Happy with your birth control?

CURRENT MEDICATIONS

Include Hormones, Vitamins, Herbal Supplements

Drug Name	Date Started	Dosage	Who Prescribed

MEDICATION ALLERGIES

Drug:	Reaction:

PAST MEDICAL HISTORY

	Yes	When		Yes	When		Yes	When
Asthma			HIV/AIDS			Glaucoma		
Blood Clots Lungs/Legs			Diabetes			Liver Disease		
Blood Transfusions			Eating Disorders			Stroke		
Constipation			Cancer			Stomach Problems		
Diarrhea			Depression/Anxiety			High Cholesterol		
Kidney Infections/Stones			High Blood Pressure			Gall Bladder Disease		
Sexually Transmitted Disease			Seizures/Epilepsy			Bleeding Disorders		
Infertility			Anemia			Migraines		
Heart Disease			Thyroid Disease			Other		

PAST SURGICAL HISTORY

Procedure	Date	Procedure	Date

SOCIAL HISTORY

Occupation				
Marital Status	Single	Married	Divorced	Widowed.
Exercise	Do you exercise regularly?		What Kind?	How Often?
Alcohol Use	Drinks per week?			
Drug Use	What kind?		How Often?	
Tobacco Use	Ever Smoked?		How much?	Number of years?

FAMILY HISTORY

	Yes	Relationship		Yes	Relationship
Asthma			High Blood Pressure		
Blood Clots Lungs/Legs			Breast Cancer		
Infertility			Ovarian Cancer		
Heart Disease			Uterine Cancer		
Diabetes			Cervical Cancer		
High Cholesterol			Colon Cancer		
Stroke			Autoimmune Disease		
Mental Illness			Other		

REVIEW OF SYSTEMS					
	Now	**Past**		**Now**	**Past**
Constitutional			Muscle or Joint Pain		
Weight Loss			**Skin**		
Weight Gain			Rash		
Fever			Sores		
Fatigue			Abnormally Dry Skin		
Change in Height			**Breasts**		
Eyes			Pain in Breasts		
Double Vision			Nipple Discharge		
Spots Before Eyes			Lumps		
Vision Changes			**Neurologic**		
Ears, Nose, Throat			Dizziness		
Earaches			Seizuures		
Ringing in Ears			Numbness		
Sinus Problems			Trouble Walking		
Sore Throat			Frequent Headaches		
Mouth Sores			**Psychiatric**		
Cardiovascular			Depression		
Chest Pain			Mood Disorder		
Shortness of Breath with Activity			Anxiety		
Swelling of Legs			**Endocrine**		
Rapid or Irregular Heartbeat			Hair Loss		
Respiratory			Heat/Cold Intolerance		
Painful Breathing			Abnormal Thirst		
Wheezing			**Hematologic/Lymphatic**		
Shortness of Breath			Frequent Bruising		
Chronic Cough			Cuts that do not Heal		
Bronchitis			Enlarged Lymph Nodes		
Gastrointestinal			**Allergies**		
Frequent Diarrhea			Latex		
Bloody Stools			Environmental		
Frequent Constipation					
Nausea/Vomiting					
Heartburn					
Genitourinary					
Blood in Urine					
Pain with Urination					
Urinary Urgency					
Urinary Frequency					
Incomplete Emptying					
Involuntary Loss of Urine					
Abnormal Bleeding					
Painful Periods					
Irregular Periods					
Pain with Intercourse					
Abnormal Vaginal Discharge					
Musculoskeletal					
Muscle Weakness					