Date: _____

Patient Intake History

Name: _____

Date of Birth: _____

Primary Care Physician: _____ Referring Physician: _____

Reason For Today's Exam: _____

Date Of Last Gynecologic Exam: _____ Was A Pap Smear Done? Y N

Obstetric History

	number		number		number
Pregnancies		Live Births		Living Children	
Premature Births (<37wks)		Miscarriages		Abortions	

No.	Year	Birth Weight	Sex	Weeks Pregnant	Type of Delivery	Complications
1						
2						
3						
4						

Current Medications

Drug Name	Dosage	Who Prescribed

Drug Name	Dosage	Who Prescribed?

Menstrual History / Gyn History

Age of Onset		Days of Flow	
Days in Cycle		Regular Cycles?	Y N

Birth Control Method			
Age At Menopause			
Date Of Last Mammogram			
		result	
Previous Breast Biopsy	Y		N

Drug Allergies

Drug	Reaction

Social History

		amount	
Tobacco Use	Y		N
Alcohol Use	Y		N
Recreational Drug Use	Y		N

Surgical History

Date	Surgical Procedure	Surgeon

Personal and Family History

	yes	family member/self
Breast Cancer	□	
Colon Cancer	□	
Uterine Cancer	□	
Ovarian Cancer	□	
Cancer (Other Locations)	□	
Asthma	□	
Lung Problem	□	
Diabetes	□	
High Blood Pressure	□	
Stroke / TIA	□	
Blood Clots (Leg/Lung)	□	
STD's	□	
Infertility	□	

	yes	family member/self
Thyroid Disease	□	
Autoimmune Disorder	□	
Kidney Problems	□	
Osteoporosis	□	
Bowel Problems	□	
Hepatitis	□	
Reflux / Hiatal Hernia	□	
Depression / Anxiety	□	
Seizure / Epilepsy	□	
Alcohol / Drug Abuse	□	
Eating Disorder	□	
Blood Transfusion	□	
Glaucoma	□	