Woman Care Ob/Gyn Intake History

Name: _____ Today's Date: _____ Date of Birth*: _____ Age: _____

Race (i.e. American Indian or Alaska Native, Asian, Black, Hawaiian / Pacific Islander, or White)*: _____

Ethnicity (i.e. Hispanic or Latino, or Not Hispanic or Latino)*:: _____ Primary Language*: _____

*Required by US Healthcare / Meaningful Use Legislation

REVIEW OF SYSTEMS Please check all that apply (within the last 3 months)

General

Y	N	
○	◉	weight loss
○	◉	weight gain/obesity
○	○	fever
○	○	fatigue
○	○	anorexia
○	○	chills
○	○	diaphoresis
○	○	insomnia
○	○	malaise
○	○	night sweats
○	○	recent illness

Visual

○ ○	double vision
○ ○	spots before eyes
○ ○	vision change
○ ○	**eye pain**
○ ○	blindness
○ ○	cataract

Ears/Nose/Throat

○ ○	nasal discharge
○ ○	ear aches
○ ○	ringing in ears
○ ○	sore throat
○ ○	mouth sores
○ ○	dental problems
○ ○	sinus problems
○ ○	sinus congestion

Cardiac

○ ○	painful breathing
○ ○	chest pain/pressure
○ ○	diffulculty breathing on exertion
○ ○	swelling of legs
○ ○	palpitations
○ ○	arrhythmia

Respiratory

Y	N	
○	○	wheezing
○	○	spitting up blood
○	○	shortness of breath
○	○	cough

GI

○ ○	diarrhea
○ ○	blood in stool
○ ○	nausea
○ ○	vomiting
○ ○	abdominal pain
○ ○	constipation
○ ○	diarrhea

Genitourinary

○ ○	blood in urine
○ ○	urinary urgency
○ ○	pain with urination
○ ○	urinary frequency
○ ○	urinary incontinence
○ ○	incomplete emptying
○ ○	menstrual irregularity
○ ○	painful intercourse
○ ○	**vaginal discharge**
○ ○	**pelvic pain**
○ ○	breast complaint

Musculoskeletal

○ ○	back pain
○ ○	bone fracture
○ ○	bone pain
○ ○	carpal tunnel syndrome
○ ○	joint complaint
○ ○	**shoulder pain**
○ ○	neck pain
○ ○	osteoporosis

Dermatologic

Y	N	
○	○	**rash / itching**
○	○	**skin lesion**
○	○	**mole change**
○	○	acne
○	○	acrochordon (skin tags)

Neurologic

○ ○	dizziness
○ ○	headache
○ ○	neck pain
○ ○	syncope
○ ○	alteration of consciousness

Psychiatric

○ ○	hyperactive / ADD / ADHD
○ ○	insomnia
○ ○	anxiety
○ ○	depression
○ ○	alcohol abuse

○ ○	dry skin
○ ○	hyperglycemia
○ ○	goiter
○ ○	hypoglycemia

Endocrine

○ ○	**dry skin**
○ ○	**chills**
○ ○	**excess hair growth**
○ ○	**hot flashes**

Hematologic

○ ○	abnormal bleeding and bruising
○ ○	anemia
○ ○	**blood clot (i.e. DVT, PE) in self or family**

Allergy

○ ○	food allergy
○ ○	anaphylactoid reaction

PLEASE COMPLETE BOTH SIDES

PLEASE LIST ANY ALLERGIES AND REACTION (INCLUDING MEDICATION, FOOD, OR ENVIRONMENTAL)

Medication/Reaction **Food or Environmental/Reaction**

_____ _____

_____ _____

Surgical History: Please list ALL surgical procedures, or hospitalizations, including year:

_____ _____

_____ _____

_____ _____

_____ _____

Medications: Please list ALL names and dosage, and frequency (including Vitamins/Herbal Supplements)

_____ _____

_____ _____

_____ _____

_____ _____

Medical History: Do you now have or have you ever had:

☐Asthma ☐Autoimmune dis ☐Arthritis ☐Anemia ☐Bleeding Disorder ☐Blood transfusion ☐Bone/Joint Disease/Fracture
☐Cancer (type?)_____ ☐Chicken pox ☐Chicken pox vaccination ☐Chlamydia ☐Chronic Lung Disease
☐Deep Vein Thrombosis ☐Depression/Anxiety ☐Diabetes Type I ☐Diabetes Type II ☐Elevated cholesterol ☐Endometriosis
☐Uterine Fibroids ☐GERD/Reflux/Ulcers ☐GI illness ☐Gestational Diabetes ☐ Glaucoma ☐Gonorrhea ☐Heart disease
☐Hepatitis ☐Herpes ☐Infertility ☐Irritable Bowel Syndrome ☐HIV ☐HPV/genital warts ☐High Blood Pressure ☐Hyperthyroid
☐Hypothyroidism ☐Liver Disease ☐Migraines ☐Osteopenia ☐Osteoporosis ☐Pelvic inflamm. disease ☐Pneumonia
☐Rheumatic Fever ☐Seizures/Epilepsy ☐Sleep Apnea ☐Stroke ☐Syphilis ☐Thyroid Disease ☐Trauma ☐Tuberculosis

Other medical problems:

_____

_____

Well Woman Update and Reproductive History: (Please provide dates where applicable)

Last bone density exam_____ (month/year) ☐ Abnormal ☐ Normal
Last colonoscopy_____ (month/year) ☐ Abnormal ☐ Normal
Last mammogram_____ (month/year) ☐ Abnormal ☐ Normal

Last Pap smear _____ (month/year) ☐ Abnormal ☐ Normal

*Have you had a Pap smear in the last 7 years? ☐ YES ☐ NO
*Have you ever had: Abnormal Pap smears? ☐ YES ☐ NO or Precancerous cells of the cervix? ☐ YES ☐ NO

If yes, any treatment? (Dates) LEEP_____ Laser _____ Cryo (freezing)_____ Cone Biopsy_____

PLEASE COMPLETE NEXT PAGE

Are you sexually active? ☐ Never ☐ Not currently ☐ Yes ☐ With Men ☐ With Women ☐ With Both
*How many lifetime sexual partners have you had? _____ *Age started sexual activity: _____
*Have you ever tested positive for a sexually transmitted infection? ☐ YES ☐ NO if yes, which:_____
*Have you ever tested positive for the HIV virus? ☐ YES ☐ NO
* Did your mother use DES in pregnancy? ☐ YES ☐ NO ☐ UNSURE

Age at first period? _____ How often do you get your menstrual cycle? Every _____ days, lasting _____days.
Are your cycles? ☐ Regular ☐ Irregular Pain/Cramps? ☐ YES ☐ NO Flow: ☐ Heavy ☐ Medium ☐ Light

Date of Last Menstrual Period (start date) _____
If menopausal, age of menopause: _____ ☐ Natural ☐ Surgical

Ever use Hormone Therapy? ☐ YES ☐ NO
HPV/ Gardasil Vaccine series completed? ☐ YES ☐ NO

Method of contraception: ☐ Not Needed ☐ None ☐ Pill ☐ Partner has Vasectomy ☐ Condoms ☐ Patch
☐ NuvaRing ☐ Depo Provera ☐ Nexplanon ☐ Mirena IUD ☐ Paragard IUD ☐ Skyla IUD ☐ Tubal Ligation
☐ Essure ☐ Rhythm Method ☐ Other_____

Obstetrical History: (number)

Pregnancies: _____ Premature: _____ Full Term:_____ Miscarriages:_____ Ectopic: _____
Abortions: _____ Multiple Births: _____ Living Children: _____

Past Pregnancies: (*only complete this section if currently of childbearing age*)
*Please list all pregnancies, including miscarriages, abortions, and ectopic pregnancies. Please include full birthdate.

Type: vaginal, C/S, forceps, or vacuum **Anesthesia:** epidural, local, general, spinal
Complications: EXAMPLES: preterm labor, diabetes, bleeding, high blood pressure, postpartum depression

Birthdate	Weeks	Labor hrs	Baby's Wt	Sex	Name of Baby	Type of Delivery	Anesthesia	Complications	Location

Family History: (Please list which family member, and maternal or paternal side) ☐ ADOPTED
Diabetes ☐ YES ☐NO _____
Stroke ☐ YES ☐ NO _____
Heart Disease ☐ YES ☐ NO _____
High Blood Pressure ☐ YES ☐ NO _____
Alcoholism ☐ YES ☐ NO _____
Breast Cancer ☐ YES ☐ NO _____
Colon Cancer ☐ YES ☐ NO _____
Ovarian Cancer ☐ YES ☐ NO _____
Other types of Cancer ☐ YES ☐ NO _____
Other _____

PLEASE COMPLETE BOTH SIDES

Social History:

Are you? ☐ Married ☐ Single ☐ Engaged ☐ Significant other ☐ Divorced ☐ Widowed ☐ Same Sex Partner

Religion (if any / optional): _____

Number of Children in Household_____ Number of Adults in Household _____

Employment: ☐ currently Employed Occupation:_____ ☐ Unemployed ☐ Retired ☐ Student

School Completed: ☐ High School ☐ College ☐ Graduate Degree ☐ Other _____

Tobacco Use: ☐ Never ☐ Current # of Cigarettes per day _____ # Years _____ ☐ Former, Quit at age _____

Any alcohol use? ☐ YES ☐ NO *If yes, the average number of drinks per day _____ per week _____

Do you use street drugs? ☐ YES ☐ NO *If yes, the type used and last use _____

Do you wear your seatbelt? ☐ YES ☐ NO

How many times per week do you exercise? (circle) 1X 2X 3X 4X 5X+
How long per session: 20 mins. 30 mins 45 mins 60+ mins

Do you eat a healthy diet? ☐ YES ☐ NO

Any history of violence or abuse in your current household or in your past? ☐ YES ☐ NO
Has anyone close to you ever threatened to hurt you? ☐ YES ☐ NO
Has anyone ever hit, kicked, choked, or hurt you physically? ☐ YES ☐ NO
Has anyone, including your partner, ever forced you to have sex? ☐ YES ☐ NO
Are you afraid of your partner? ☐ YES ☐ NO

Form Completed by: ☐ Patient □ Office staff □ Provider

Signature of Patient: _____

Date Reviewed by Provider with Patient: _____/_____/_____

Provider Signature: _____

Annual Review of History:

Date reviewed: _____ Signature of Provider: _____

Date reviewed: _____ Signature of Provider: _____