

Name:

## PATIENT INTAKE HISTORY

WHY HAVE YOU COME TO THE OFFICE TODAY?

IF YOU ARE HERE FOR AN ANNUAL EXAM, IS THIS A PRIMARY CARE VISIT  OR GYNECOLOGY ONLY

DO YOU HAVE A NEW PROBLEM?

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

## GYNECOLOGIC HISTORY

PROVIDER NOTES

LAST NORMAL MENSTRUAL PERIOD (FIRST DAY) / /

AGE PERIODS BEGAN:

LENGTH OF PERIODS (NUMBER OF DAYS OF BLEEDING):

NUMBERS OF DAYS FROM THE BEGINNING OF ONE PERIOD TO THE NEXT:

ANY RECENT CHANGES IN PERIODS?

DO YOU HAVE PROBLEMS WITH YOUR PERIODS?

PAIN: \_\_\_\_\_ MEDICATION USED: \_\_\_\_\_ IS IT EFFECTIVE? \_\_\_\_\_

HEAVY BLEEDING? \_\_\_\_\_ NUMBER OF HEAVY DAYS: \_\_\_\_\_

DOES YOUR PERIOD AFFECT YOUR QUALITY OF LIFE?

DO YOU BLEED BETWEEN PERIODS?

HAVE YOU EVER HAD SEX?

ARE YOU CURRENTLY SEXUALLY ACTIVE?

NUMBER OF SEXUAL PARTNERS IN THE PAST YEAR:

SEXUAL PARTNERS ARE: MEN  WOMEN  BOTH

DO YOU USE BIRTH CONTROL?

TYPE: \_\_\_\_\_ LENGTH OF USE: \_\_\_\_\_

ARE YOU SATISFIED WITH YOUR CURRENT METHOD OF BIRTH CONTROL?

DO YOU DESIRE PREGNANCY: NOW  FUTURE

HAVE YOU COMPLETED YOUR CHILDBEARING? YES  NO  NOT SURE

WHEN WAS YOUR LAST PAP TEST?

WHAT WAS THE RESULT?

HAVE YOU EVER HAD AN ABNORMAL PAP TEST?

DO YOU DO BREAST SELF-EXAMINATIONS?

HAVE YOU BEEN EXPOSED TO DIETHYLSTILBESTROL (DES)?

# MEDICAL HISTORY UPDATE

PLEASE LIST ANY MEDICATIONS THAT YOU ARE TAKING. INCLUDE VITAMINS, SUPPLEMENTS AND HERBS.

DRUG NAME	DOSAGE	PRESCRIBED BY

PLEASE LIST ANY SURGERIES OR HOSPITALIZATIONS SINCE YOU WERE LAST HERE..

SURGERY/HOSPITALIZATION	REASON

PLEASE LIST ANY RECENT MEDICAL PROBLEMS.


**SOCIAL HISTORY**

	NEVER	CURRENT/AMOUNT USED	FORMER/WHEN STOPPED
CAFFEINE			
TOBACCO			
ALCOHOL			
RECREATIONAL DRUGS			

	YES	NO
HAVE YOU EVER BEEN PHYSICALLY, SEXUALLY OR EMOTIONALLY ABUSED?		
ANY NEW FAMILY HISTORY?		

IF YES, EXPLAIN: