HISTORY INTAKE

Welcome to our practice! Please help us meet all your healthcare needs by completing this form to the best of your knowledge. If you have any questions or need assistance please ask us. We will be happy to help.

Today's Date: _____

Name: _____ **Age**: _____ **Birthday**: _____

Primary Care Physician: _____

Imaging Center: _____

Pharmacy (specify address): _____

Current Medication (both over the counter and prescription):

_____

_____

_____

Drug Allergies: _____

_____

GYNECOLOGIC HISTORY (check all that apply):

Frequent vaginal infections U Urine loss or leakage Hot flashes/Night sweats Difficulty sleeping
Vaginal dryness Decreased libido Frequent bladder infections Pain with intercourse
Chronic itching Breast tenderness Genital sores Endometriosis Fibroids

PAST PREGNANCY HISTORY:

Total #	Full term	Premature	Spont. Ab	Induced Ab	Ectopic	Multiples	Living
_____	_____	_____	_____	_____	_____	_____	_____

#	Month/Year	Birth Weight	# of Weeks	Delivery Type	Complications
1				Vag / C-Sect / V-Bac	
2				Vag / C-Sect / V-Bac	
3				Vag / C-Sect / V-Bac	
4				Vag / C-Sect / V-Bac	
5				Vag / C-Sect / V-Bac	
6				Vag / C-Sect / V-Bac	

MENSTARUAL HISTORY:

What age did you start? _____
Last menstrual cycle (start date): _____ If menopausal, what age? _____
Duration of cycle: _____days
Days between cycles: _____days
Pain with cycles? YES / NO
History of sexually transmitted diseases or infections (past or present? YES / NO
If yes, which one(s): _____
Current birth control (if any): _____

PAP/MAMMO/BONE DENSITY HISTORY:

Last Pap Smear: _____ Results: Normal / Abnormal
If abnormal, why: _____
Last Mammogram: _____ Results: Normal / Abnormal
If abnormal, why: _____
Last Bone Density Scan (if of age): _____ Results: Normal / Abnormal
If abnormal, why: _____

MEDICAL HISTORY (check all that apply):

_____ Abnormal Pap ____Anemia ____ AIDS/HIV ____Asthma ____Bladder infections
____Blood in urine ____Blood transfusion _____ Breast problems _____ Blood clot in leg/lungs
____ Heart disease ____Hypertension ____ In utero exposure to DES ____Infertility
____Kidney disease ____Liver disease ____Lupus ____Osteopenia ____ Osteoporosis
____Rheumatoid arthritis ____ Seizures ____ TB or exposure to TB _____ Thyroid (hyper/hypo)

SURGICAL HISTORY:

List any surgeries or procedures and year they were done: _____

_____

_____

_____

SOCIAL HISTORY:

____Single ____Married _____Divorced _____Separated

_____Smoke? If yes, how many packs a day: _____ If quit, what year? _____

_____Drink? If yes, how many drinks/beers a week: _____

_____Prescription drug use/ abuse? If yes, what drug(s): _____

_____ Illicit drugs (marijuana, cocaine, meth, PCP) If yes, what drug(s): _____

Exercise: ____Occasional _____Low _____Moderate _____High

Sexually active (circle): YES / NO Sexual orientation (circle): Heterosexual / Homosexual /Bisexual

Would you accept a blood transfusion in an emergency (circle): YES / NO

FAMILY HISTORY:

Please list any family history of Breast, Ovarian, or Colon cancer (please specify maternal or paternal):

_____

_____

_____

List any other type of cancer/illness and specify family member (Mom, Dad, Sister, Brother, etc.)

(Maternal or Paternal): _____

_____

_____