Obstetrics & Gynecology Intake form

Visit Date: _____

PATIENT INFORMATION	
Patient name *(last, first, M.I):*	**Date Of Birth:** Age:
Reason for visit :	

ALLERGIES – (WRITE NONE IF YOU DO NOT HAVE ANY ALLERGIES)	
Allergy:	Reaction:
Allergy:	Reaction:

CURRENT MEDICATIONS: *Include prescribed, over-the-counter drugs, folic acid or vitamins, herbal remedies or supplements, inhalers, etc.:*

Name of medication	strength/dose	Frequency taken	Reason for taking

☐ Yes ☐ No	**High blood pressure**	☐ Yes ☐ No	**Heart disease (MI)**	☐ Yes ☐ No	**Seizures**
☐ Yes ☐ No	**Migraines**	☐ Yes ☐ No	**CVA/TIA/Stroke**	☐ Yes ☐ No	**Liver/Gall bladder disease**
☐ Yes ☐ No	**High cholesterol**	☐ Yes ☐ No	**Diabetes**	☐ Yes ☐ No	**Ulcers**
☐ Yes ☐ No	**Blood clotting**	☐ Yes ☐ No	**Cancer**	☐ Yes ☐ No	**Other:**

SURGICAL HISTORY

Year	Type of surgery			Reason for surgery

Family history of major illnesses? *(mother, father, siblings)*	☐ Yes	☐ No
Maternal relatives with breast, ovarian, uterine, or colon cancer? *(aunts, grandmother)*	☐ Yes	☐ No

SOCIAL HISTORY

Do you smoke cigarettes? ☐	Yes - How many/day?	How many years?	☐ Quit, year:	☐ **No**
Do you drink alcohol? ☐	Yes - How many/day?	How many/week?		☐ **No**
Do you use marijuana, cocaine, or any other similar drug? ☐	Yes - describe			☐ **No**
Exercise regularly? ☐	Yes, *How many hours/week?* ☐	Moderate (walking, yoga):	☐ Vigorous (running):	☐ **No**

Current or most recent job:

GENETIC HISTORY: Please list If you have known genetic issues (eg sickle cell, cystic fibrosis):

OBSTETRIC HISTORY (PLEASE FILL IF YOU ARE HERE FOR PREGNANCY CARE)

LIST HIGH RISK PREGNANCY ISSUES IF ANY (IVF, Twins, etc:

TOTAL PREGNANCIES ____ FULL TERM ____ PREMATURE ____ MISCARRIAGES ____ ABORTIONS ____ # OF CHILDREN ___

(Please list all pregnancies in order, including miscarriages, premature births, stillbirths, ectopics (tubal), and abortions)

Year	Pregnancy outcome (e.g. vaginal delivery, c-section, miscarriage, abortion)	Length of Pregnancy (wk/mo)	Weight	Sex (M/F) Name	Problems/Complications (e.g. preterm labor, high blood pressure, diabetes, blood transfusion, infection)

GYN HISTORY

Age of First Period:	Menstrual periods: ☐ Regular ☐ Irregular
Last menstrual period (first day): / /	Flow (check one): ☐ Light ☐ Moderate ☐ Heavy
Days between cycles: Days of bleeding:	Do you have pain with periods? ☐ Yes ☐ No
When was your last pap smear?: (month/year)	☐ Normal ☐ Abnorpmal

Current Birth Control:

INFECTION HISTORY

☐ **None** ☐ Chlamydia ☐ Gonorrhea ☐ Genital Herpes ☐ Trichomoniasis
☐ Syphilis ☐ HIV/AIDS ☐ Genital warts/HPV ☐ Pelvic Inflammatory disease ☐ Other:

PREVENTIVE CARE

Have you ever had a mammogram? ☐ Yes - date:	☐ No ☐ n/a	☐ Normal ☐ Abnormal
Have you ever had a bone density scan? ☐ Yes - date:	☐ No ☐ n/a	☐ Normal ☐ Abnormal
Have you ever had a colonoscopy? ☐ Yes - date:	☐ No ☐ n/a	☐ Normal ☐ Abnormal

Have you received the HPV vaccine? ☐ Yes ☐ No Shots received (choose one) ☐ 1 ☐2 ☐3

Is there anything else you would like to discuss with the doctor: