Patient Intake:

__________________________ ____/____/______

Patient's First and Last Name   Date of Birth

Chief Complaint/ Reason for Visit:____

Date Onset:________________________________

Have you been treated for this condition in the past? **Yes/ No** If yes, please Explain?__________________________

____

MEDICAL HISTORY: Mark the following medical issues or conditions

Surgeries	**Reason for Surgery**
had Hysterectomy YES or NO	(*circle*) vaginal, laparoscopic, or abdominal
Fallopian Tubes removed YES or NO	(*circle*) Right / Left / Both
Ovaries removed YES or NO	(*circle*) Right / Left / Both
Uterine Prolapse YES or NO	(*circle*) Repaired: YES or NO
Other Surgeries	

- ☐ Lupus
- ☐ Mental Illness
- ☐ Mood Disorder
- ☐ Pneumonia
- ☐ Seizure Disorder
- ☐ STD
- ☐ Stomach Problems
- ☐ Stroke/ TIA
- ☐ Thyroid Disease
- ☐ Thyroid Dysfunction
- ☐ Tuberculosis- TB
- ☐ Ulcers
- Other______________________

- ☐ Bipolar Disorder
- ☐ Bleeding Disorders
- ☐ Blood Transfusions
- ☐ Bowel Trouble

- ☐ Date of Last Colonscopy______________
- ☐ Date of Last DEXA__________________
- ☐ Date of Last Mammo_______________
- ☐ Date of Last PAP _________________
- ☐ History of Abnormal Papsmear
- ☐ History of Sexual/physical/emotional abuse
- ☐ (if yes, please explain):
- ☐
- ☐ AAD/ ADHD
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma

- ☐ Cancer
- ☐ Chronic Lung Disease
- ☐ Chronic Pain
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Indigestion
- ☐ Kidney Problems

SURGICAL, HOSPITALIZATION AND MEDICAL ILLNESS HISTORY

MEDICATIONS

Please list any Medication (with Dosage) you are currently taking:

Are you now, or have you ever taken hormones? YES or NO	If yes, please list past/current type: (ex. pill/cream)

ALLERGY LIST

Environmental	*Reaction*	Food	*Reaction*	Medications	*Reaction*

Patient Name ______________________

FAMILY MEDICAL HISTORY-Check if your blood relatives have had:

Major Illnesses (All categories)	Yes	No	Family Member
Asthma			
Breast Cancer			
Cancer			
Chronic Lung Disease			
Colon Cancer			
Depression/Anxiety/Mood Disorders			
Diabetes			
Heart Trouble			
Hepatitis/ Jaundice			
High Blood Pressure			
High Cholesterol			
Kidney Infection/ Stones			
Osteoporosis			
Strokes			
Thyroid Disease			
Tuberculosis- TB			
Other			

REPRODUCTIVE HISTORY

Age you started your period	_____ How many days between your period? _____
How long does your period last?	_____ **Flow**: *{ } Low { } Medium { } Heavy* **# of tampons per day? ____ # of Pads? _____**
Date of last menstrual cycle:	__________ Age at 1st papsmear**:**________ **History of abnormal papsmear: yes or no**
Postmenopausal: **YES / NO** ⇨	**Age Menopause: __________**
Contraception: **YES / NO** ⇨	***Method*: Pill** Condom **IUD** Nexplanon **Depo** Nuva Ring **Patch** Withdrawel **Natural/Rhythm** Tubal Partner w/ Vasectomy
Pregnant: **YES / NO** ⇨	**Who is your emotional support? Boyfriend: Spouse: Other:**
History of STD? **YES/ NO** ⇨	**Gonorrhea** Chlamydia **Trich** Herpes **HPV** Syphilis **HIV** Hepatitis C

Pregnancy History

	Number		Number
Total # of Pregnancies		**Full term births**	
Premature		**Abortions Induced**	
Miscarriages		**Living children**	

Pregnancy Details

No.	DOB	Wks Gest	Labor (hrs)	Baby's Wt/ Sex	Del Type Vag or C/S	Anes?	Early Labor?	Wt Gain	Comments/ Complications	Location
1										
2										
3										
4										
5										

6											

SOCIAL HISTORY

Tobacco (substance)	**YES** **NO**	Amount use:	Age Start: Age Stop:
Alcohol (substance)	**YES** **NO**	Amount use:	Age Start: Age Stop:
Recreational Drugs (substance)	**YES** **NO**	**If yes, type**____	
Marital Status:	**Single** **Divorced**	**Separated** **Widowed** **Married**	spouse or partners name:
Exercise Regularly	**YES** **NO**		
Uses Seatbelts (Travel)	**YES** **NO**		
Emergency Contact:		**PHONE #:** **Relationship:**	
Sexual Preference: (circle) Male Female Both		**Choose not to disclose** **other, please specify**_____________________	**Don't know**
Gender Identity		(circle) Male Both Transgender Male Transgender Female Other, please explain: Female choose not to disclose	
Occupation:		Where:	Work Number: