OB-GYN Centre of Excellence Patient Intake Form

For Office Use Only

BP:______________	Height: ______________
Pulse: ___________	Weight:______________
Temp: ___________	LMP:______________

Name: ____________________________________ Today's Date: ________

Date of Birth:________________________________ Age: _______________

Primary Care Physician: ____

Reason for Visit Today: (Problems during a wellness exam are subject to an additional charge. This additional charge may result in a copay/coinsurance/deductible payment due. Some insurance companies require a separate visit for problems. You may be asked to return for the problem)

☐ Wellness Exam ☐ Wellness Exam with Problems (Please List)____

☐ Other: ____

Can we leave test/lab results or appointment information on your voice mail or answering machine? ☐ Yes ☐ No

Patient History

Allergies: ____

Pregnancy Prevention: ☐ Pills ☐ Condoms ☐ Depo Provera ☐ IUD ☐ Nexplanon ☐ Surgical Sterilization ☐None

If birth control pills, list medication: ____

Patient Medical History – *Please check all that apply and list medication to treat condition:*

Condition:	**Medication(s) with dosage:**
☐ Arthrits ______________________	____
☐ Asthma ______________________	____
☐ Bleeding tendency______________	____
☐ Cancer ______________________	____
☐ Diabetes______________________	____
☐ Depression/anxiety/mental illness_________	____
☐ Heart trouble __________________	____
☐ Hepatitis ______________________	____
☐ HIV/AIDS ______________________	____
☐ High blood pressure ______________	____
☐ Hormone replacement therapy _________	____
☐ Stroke/deep vein thrombosis____________	____
☐ Seizures ______________________	____
☐ Sexually transmitted disease ____________	____
☐ Thyroid disorder ________________	____
☐ Other______________________ _	____
☐ Other ______________________ _	____

Past Surgical History: *Please list all previous surgeries/serious injuries including dates*

Hysterectomy: ☐ Abdominal ☐ Laparoscopic ☐Robotic ☐ Vaginal ____

____ **Date:** ______________________

____ **Date:** ______________________

____ **Date:** ______________________

____ **Date:** ______________________

Family History - Please Check All That Apply**:**

Disease	Mother	Father	Brother	Sister	Son	Daughter	Grand mother	Grand father	Aunt	Uncle
Pancreatic Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cystic Fibrosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression/Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Genetic Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ovarian Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Uterine Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other Please list below:										

Menstrual History:

Age of 1st Period: _________ # of Days between Periods ____________

# of Days Periods last: ___________ Flow: ☐ Light ☐ Medium ☐ Heavy

Use: ☐ Tampons or ☐ Pads # Used per Day: _________

Date of Last Period: _____________ Certainty of LMP Date: ___________%

Sexually Active: ☐ No ☐ Yes

Menopause Status: ☐Premenopausal ☐Perimenopausal ☐Postmenopausal Age Onset: _________

Pregnancy History:

# of Pregnancies: _____ # Full Term: _____ # Premature: _____ # Miscarriage: ______ # Abortions: _____ # Ectopics:_____

# of Vaginal Deliveries: _____ # of C-Sections: _____

Date of Delivery	Total Weeks Pregnant	Hours Labor	Birth Weight	Sex	Type of Delivery	Method of Anesthesia	Early Labor	Complications	Location of Delivery

Details regarding pregnanies you feel the doctor should know:

Social History – *Please Circle One*:

Marital Status:	Single	Married	Separated	Divorced	Widowed
Use of Alcohol:	Never	Rarely	Moderate	Daily	
Use of Tobacco:	Never	Quit	Current packs/day: ___________________________________		
Use of Drugs:	Never	Type/Frequency: ____			

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 ever afraid of your partner: ☐ Yes ☐ No

Preventative Screening/Immunizations - *Please select all that apply and date performed/given:*

☐ Cervical Cancer Screening (Pap Smear):______________

☐ Mammogram: ______________________

☐ Colonoscopy ________________________

☐ Bone Density: ______________________

Do you perform monthly breast exams: ☐ Yes ☐ No

☐ Flu Vaccination: ____________________

☐ HPV (Gardisail Vaccination) ☐ Series 1 ☐ Series 2 ☐ Series 3

☐ TDap Vaccination ___________________

High Risk Assessment Critera - *Please check all that apply:*

☐ Vaginosis ☐ Genital Warts ☐ Chlamydia ☐ Gonorrhea ☐Trichomonas ☐Syphilis

Have you had a Pap smear in the last 7 years: ☐ Yes ☐ No

Have you ever had an abnomal pap test: ☐ Yes ☐ No

Did you begin sexual activity before you were 16 years old: ☐ Yes ☐ No

Have you had more than 5 sexual partners in your lifetime: ☐ Yes ☐ No

Have you ever tested positive for HIV virus: ☐ Yes ☐ No

Did your mother take the drug DES when she was pregnant with you: ☐ Yes ☐ No

REVIEW OF SYSTEMS

Please check all symptoms that apply:

Constitutional Symptoms
- Good general health lately ☐
- Recent weight gain ☐
- Recent weight loss ☐
- Fatigue ☐
- Fever ☐
- Chills ☐

Eyes
- Impaired vision (glasses/contacts) ☐
- Peripheral vision changes ☐
- Glaucoma ☐

Ears/Nose/Throat
- Chronic sinus problems ☐
- Nose bleeds ☐
- Voice change or sore throat ☐
- Thyroid Mass ☐

Breast
- Rash ☐
- Itching ☐
- Tenderness ☐
- Swelling ☐
- Lumps ☐
- Nipple discharge ☐

Cardiovascular
- Chest pain ☐
- Irregular heart beats ☐
- Shortness of breath walk/lying flat ☐
- Rapid heart rate ☐
- Swelling of feet, ankles or hands ☐
- Varicose veins ☐

Respiratory
- Chronic or frequent coughs ☐
- Coughing up blood ☐
- Shortness of breath ☐
- Asthma or wheezing ☐
- TB Exposure ☐

Gastrointestinal
- Loss of appetite ☐
- Abdominal pain ☐
- Change in bowel movements ☐
- Nausea ☐
- Vomiting ☐
- Diarrhea ☐
- Constipation ☐
- Unable to restrain stools ☐
- Blood with bowel movement ☐
- Heartburn ☐
- Polyps ☐

Urinary and Reproductive
- Kidney stones ☐
- Urgency to urinate ☐
- Frequent urination ☐
- Leaking urine with sneezing ☐
- Blood in urine ☐
- Leaking urine with urgency ☐
- Burning or painful urination ☐
- Possibility of pregnancy ☐
- Post-coital bleeding ☐
- Significant PMS ☐
- Irregular periods ☐
- Heavy periods ☐
- Painful periods ☐
- Painful intercourse ☐
- Pelvic pain ☐
- Bloating ☐
- Periods stopped ☐
- Taking hormones ☐
- Hot flashes/night sweats ☐
- Lack of sexual desire ☐
- Postmenopausal bleeding ☐
- Unusual vaginal discharge ☐
- Vaginal dryness ☐
- Hysterectomy ☐
- Ovaries removed ☐

Integument (Skin)
- Rash ☐
- Itching ☐
- Hair growth change ☐
- New skin lesions ☐
- Recent changes to skin ☐
- Acne ☐

Neurological
- Tingling or numbness ☐
- Seizures ☐
- Frequent headaches ☐
- Light headed or dizzy ☐
- Moodiness ☐

Musculoskeletal
- Joint pain ☐
- Joint swelling ☐
- Limitation of motion ☐
- Muscle cramps ☐
- Back pain ☐

Endocrine
- Cold intolerance ☐
- Heat intolerance ☐
- Diabetes ☐
- Excessive thirst or urination ☐
- Skin dryness ☐

Psychiatric
- Anxiety ☐
- Depression ☐
- Difficulty sleeping ☐
- Excessive anger ☐
- Memory loss or confusion ☐
- Nervousness ☐
- Moodiness ☐
- Suicidial or homicidal thoughts ☐

Blood and Lymph
- Easy bleeding ☐
- Easy bruising ☐
- Slow to heal after cuts ☐
- Anemia ☐
- Blood clots ☐
- Past transfusion ☐
- Enlarged glands/lymph nodes ☐

Allergy
- Sinus allergy symptoms ☐
- Frequent illness ☐
- Allergic skin conditions ☐
- Autoimmune problems ☐