OB-GYN Centre of Excellence Patient Intake Form

For Office Use Only

Name: _____ Today's Date: _____

Date of Birth:_____ Age: _____

Primary Care Physician: _____

*BP:*_____	*Height:* _____
Pulse: _____	*Weight:*_____
Temp: _____	*LMP:*_____

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

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

Pregnancy Prevention**:** ☐ Pills ☐ Condoms ☐ Depo Provera ☐ IUD ☐ Nexplanon ☐ Surgical Sterilization ☐ Partner Vasectomy ☐None If birth control pills, list medication: _____

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 pregnancies you feel the doctor should know:

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 _____	_____

Please list any past medical conditions not listed above:

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

Hysterectomy: ☐ Abdominal ☐ Laparoscopic ☐Robotic ☐ Vaginal _____

_____ **Date:** _____

_____ **Date:** _____

_____ **Date:** _____

_____ **Date:** _____

Allergies: _____

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:										

*Please put an "M" for Mother's side and "F" for Father's side. Only on Grandparents, Aunt, and Uncle.

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: _____

☐ Flu Vaccination: _____

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

☐ TDap Vaccination _____

Do you perform monthly breast exams: ☐ Yes ☐ No

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 ☐