Women & Adolescents Gynecology Center
Intake History

Name ________________________________ Birth Date __________ Date _______________
Address ______________________________ City ______________ State/Zip________________
Home # _________________ Work # ___________________ Cell # _________________
Name of Spouse/Partner _____________________ Referred by __________________________

Medicine Allergies – List and reaction to each
____
____
____
____
____

Latex Allergy □ YES □ NO

Prescription Drugs and dosages
____
____
____
____
____
____
____
____
____
____

IUD type: ___________________
Date Inserted: ________________
Vitamins/Herbs
____
____
____
____

Do you smoke? □ YES □ NO
Alcohol Consumption □ YES □ NO
Amount ___________________
Illicit Drug Usage □ YES □ NO
Amount ___________________
Type ______________________

Immunizations

Type	Year
T-D booster	_______
Influenza vaccine	_______
MMR vaccine	_______
Hepatitis B vaccine	_______
Pneumococcal vaccine	_______
Gardasil	_______

Pregnancy History
Enter the number of:

Times pregnant	_______
Premature births	_______
Miscarriages	_______
Abortions	_______
Live births	_______
Living children	_______

Illnesses

Check where you or your parents, grandparents, aunts, uncles, brothers or sisters have had the following illnesses or problems:

	You	Your Family		If family member, list who and if maternal or paternal
1.	□	□	Abnormal pap smear	________________________
2.	□	□	Abuse: sexual, physical, emotional	________________________
3.	□	□	Alzheimers'/Dementia	________________________
4.	□	□	Anemia	________________________
5.	□	□	Anesthesia reaction	________________________
6.	□	□	Arthritis (type)	________________________
7.	□	□	Asthma	________________________
8.	□	□	Birth Defects	________________________
9.	□	□	Bleeding Disorder	________________________
10.	□	□	Blood transfusions	________________________
11.	□	□	Bowel disorder (specify)	________________________
12.	□	□	Breast disease (specify)	________________________
13.	□	□	Cancer (specify) _____________	________________________
14.	□	□	Chemical or alcohol dependency	________________________
15.	□	□	Colon polyps	________________________
16.	□	□	Depression/Anxiety (specify)	________________________
17.	□	□	Diabetes (specify type)	________________________
18.	□		Eating disorders (specify type)	________________________
19.	□	□	Epilepsy/Seizures	________________________
20.	□	□	Eye disease (specify type)	________________________
21.	□	□	Headaches/migraines	________________________
22.	□	□	Heart disease (specify type)	________________________
23.	□	□	Heartburn	________________________
24.	□	□	Hepatitis/jaundice	________________________
25.	□	□	Herpes (genital/oral)	________________________
26.	□	□	High blood pressure	________________________
27.	□	□	Kidney/bladder problems	________________________
28.	□	□	Lung disease/tuberculosis	________________________
29.	□	□	Lupus/autoimmune disease	________________________
30.	□	□	Mental illness	________________________
31.	□	□	Osteoporosis	________________________
32.	□	□	Pelvic disorders (specify type)	________________________
33.	□	□	Phlebitis/blood clots	________________________
34.	□	□	PMS	________________________
35.	□	□	Rheumatic fever	________________________
36.	□	□	Serious accident	________________________
37.	□		Sexually transmitted disease (type)	________________________
38.	□		Sleep apnea	________________________
39.	□	□	Stroke	________________________
40.	□	□	Suicide attempt	________________________
41.	□	□	Thyroid problems	________________________
42.	□	□	Ulcers	________________________
42.	□	□	Varicose veins	________________________
43.	□	□	Venereal warts	________________________
44.	□	□	Other diseases/illnesses	________________________

Hospitalizations: (Please include short-stay surgery)
Please list previous hospitalizations for surgery or illness

Date	Type of Surgery or Illness
___________	___________________________________
___________	___________________________________
___________	___________________________________
___________	___________________________________
___________	___________________________________

Have you ever had a blood transfusion? ◻ Yes ◻ No

Menstrual/Sexual History
Age when period started ___________
Number of days period lasts ___________
Number of days between periods __________
Contraceptive method ___________ Tubal ____ Vasectomy____
Condoms___________

Age of menopause __________

Are you sexually active now? ◻ Yes ◻ No
With? ◻ Female ◻ Male
Do you practice safe sex? ◻ Yes ◻ No

Lifestyle Questions

Do you consider yourself to be in good health? ◻ Yes ◻ No If no, explain: ____

Who is your primary doctor and location? ____

Ethnic Background: ________________________ Circle which applies: Married Single Divorced Separated

Do you exercise regularly? ◻ Yes ◻ No

Do you sleep well? ◻ Yes ◻ No

Do you find your work satisfactory? ◻ Yes ◻ No

Do you feel that the stresses in your life are manageable? ◻ Yes ◻ No

Do you eat Breakfast _________ Lunch __________ Dinner ___________

Are you a vegetarian or on a special diet? ◻ Yes ◻ No

Do you use caffeine? ◻ Yes ◻ No How much? ____

Are you currently eating/drinking milk products or taking supplemental calcium? ◻ Yes ◻ No How much? ________________

Have you been physically, sexually or emotionally abused? ◻ Yes ◻ No By Whom: __________________________________

Seat belt use: Always Seldom Never

Do you perform Self Breast Exams monthly? ◻ Yes ◻ No

Completed by: ____________________________________ **Date:** _________________

Reviewed by: ____________________________________ **Date:** _________________

Reviewed by: ____________________________________ **Date:** _________________

Reviewed by: ____________________________________ **Date:** _________________