Partners We care for life

PARTNERS in OBSTETRICS and GYNECOLOGY

PATIENT INTAKE HISTORY

PATIENT NAME:	BIRTH DATE: / /	DATE: / /

If you are uncomfortable answering any questions, leave them blank; you can discuss them with your doctor or nurse.

GYNECOLOGIC HISTORY

Allergies:	Physician's Notes
Last Normal Menstrual Period (First Day): / /	
Age Periods Began:	
Length of Periods (Number of Days of Bleeding):	
Number of Days Between Periods:	
Any Recent Changes in Periods?	
Are you currently sexually active?	
Have you ever had sex?	
Present method of birth control?	
When was your last Pap smear?	
What was the result?	
Have you ever had an abnormal Pap smear?	
What year/How was it treated?	
Have you received Gardasil vaccine?	

OBSTETRIC HISTORY

	NUMBER		NUMBER		NUMBER		NUMBER
Pregnancies (including present)		Abortions		Ectopics		Miscarriages	
Premature Births (< 37 weeks)		Live Births		Adopted Children		Living Children	

No.	Birth Date	Weight at Birth	Baby's Sex	Weeks Pregnant	Type of Delivery (Vaginal, Cesarean, etc.)	Complications?
1.						
2.						
3.						
4.						

Physician's Notes on Obstetric History:

CURRENT MEDICATIONS

(Including hormones, vitamins, herbs, nonprescription medications)

Drug Name	Dosage	Who Prescribed	Drug Name	Dosage	Who Prescribed

OPERATIONS / HOSPITALIZATIONS

REASON	DATE	HOSPITAL

PERSONAL PAST HISTORY OF ILLNESSES

MAJOR ILLNESS	YES (DATE)	NO	NOT SURE	PHYSICIAN'S NOTES
Asthma				
Pneumonia/Lung Disease				
Kidney Infections/Stones				
Tuberculosis				
Sexually Transmitted Disease				
HIV/AIDS				
Heart Attack/High Cholesterol				
Diabetes				
High Blood Pressure				
Stroke				
Rheumatic Fever				
Blood Clots in Lungs or Legs				
Eating Disorders				
Collagen Vascular Disease (Lupus)				
Chickenpox or Vaccine				
Cancer				
Reflux/Hiatal Hernia/Ulcers				
Depression/Anxiety				
Anemia				
Blood Transfusions				
Seizures/Convulsions/Epilepsy				
Bowel Problems				
Migraines				
Cataracts/Glaucoma				
Arthritis/Joint Pain/Back Problems				
Broken Bones				
Hepatitis/Hepatitis Vaccine/Liver Disease				
Thyroid Disease				

Previous Tests	**Yes**	**No**	**Date/Result**
Mammogram			
Colonoscopy			
Cholesterol			
Bone Density			

SOCIAL HISTORY

MARITAL STATUS: ❑ SINGLE ❑ RELATIONSHIP WITH SIGNIFICANT OTHER ❑ MARRIED (OPPOSITE SEX) ❑ MARRIED (SAME SEX)
❑ DIVORCED ❑ SEPARATED ❑ WIDOWED

WHO DO YOU LIVE WITH?_____

	YES	NO	PHYSICIAN'S NOTES
ARE YOU CURRENTLY SMOKING?	❑	❑	PACKS PER DAY:
HAVE YOU SMOKED IN THE PAST?	❑	❑	YEARS YOU QUIT:
ARE YOU EXPOSED TO SECOND HAND SMOKE?	❑	❑	
DO YOU DRINK ALCOHOL?	❑	❑	DRINKS PER WEEK:
DO YOU USE RECREATIONAL DRUGS?	❑	❑	
DO YOU EXERCISE?	❑	❑	TYPE/FREQUENCY:
DO YOU TAKE CALCIUM/DAIRY INTAKE?	❑	❑	AMOUNT/DAY
HAVE YOU BEEN PHYSICALLY OR SEXUALLY ABUSED, THREATENED,OR HURT BY ANYONE?	❑	❑	
WHAT IS YOUR OCCUPATION?			

FAMILY HISTORY (PARENTS, GRANDPARENTS, SIBLINGS, CHILDREN)

MOTHER: ❑ LIVING ❑ DECEASED – CAUSE: AGE: | FATHER: ❑ LIVING ❑ DECEASED – CAUSE AGE:

SIBLINGS: NUMBER LIVING: NUMBER DECEASED: CAUSE(S)/AGE(S):

CHILDREN: NUMBER LIVING: NUMBER DECEASED: CAUSE(S)/AGE(S):

ILLNESS	YES	WHICH RELATIVE(S) AND AGE OF ONSET	PHYSICIAN'S NOTES
DIABETES	❑		
STROKE	❑		
HEART DISEASE	❑		
BLOOD CLOTS IN LUNGS OR LEGS	❑		
HIGH BLOOD PRESSURE	❑		
HIGH CHOLESTEROL	❑		
OSTEOPOROSIS (WEAK BONES)	❑		
HIV/AIDS	❑		
BIRTH DEFECTS	❑		
DRINKING OR DRUG PROBLEMS	❑		
BREAST CANCER	❑		
COLON CANCER	❑		
OVARIAN CANCER	❑		
UTERINE CANCER	❑		
MENTAL ILLNESS/DEPRESSION	❑		
ALZHEIMER'S DISEASE	❑		
OTHER	❑		

Please check (x) if any of the following apply to you currently.

	CURRENTLY
1. CONSTITUTIONAL	
Weight loss	☐
Weight gain	☐
Fever	☐
Fatigue	☐
2. EYES	
Double vision	☐
Spots before eyes	☐
Vision changes	☐
3. ENT / MOUTH	
Ear aches	☐
Ringing in ears	☐
Sinus problems	☐
Sore throat	☐
Mouth sores	☐
Dental problems	☐
4. CARDIOVASCULAR	
Painful breathing	☐
Chest pain	☐
Difficult breathing on exertion	☐
Swelling of legs	☐
Palpitations of heart	☐
5. RESPIRATORY	
Wheezing	☐
Spitting up blood	☐
Shortness of breath	☐
Cough, chronic	☐
6. GASTROINTESTINAL	
Diarrhea, frequent	☐
Bloody stool	☐
Nausea / vomiting	☐
Constipation	☐
7. GENITOURINARY	
Blood in urine	☐
Pain with urination	☐
Urgency	☐
Frequency of urination	☐
Incomplete emptying	☐
Stress incontinence	☐
Abnormal periods	☐
Painful intercourse	☐

	CURRENTLY
8. MUSCULOSKELETAL	
Muscle weakness	☐
9. SKIN / BREAST	
Pain in breast	☐
Discharge	☐
Masses	☐
Rash	☐
Ulcers	☐
10. NEUROLOGICAL	
Dizziness	☐
Seizures	☐
Numbness	☐
Trouble walking	☐
11. PSYCHIATRIC	
Depression	☐
Crying, frequent	☐
12. ENDOCRINE	
Dry skin	☐
Abnormal thirst	☐
Hot flashes	☐
13. HEMATOLOGIC / LYMPHATIC	
Bruises, frequent	☐
Cuts do not stop bleeding	☐
Enlarged lymph nodes	☐
14. ALLERGIC/IMMUNOLOGIC	
Clear nasal discharge	☐
Recurrent infections	☐