HISTORY INTAKE

Date: ________________________________

Last Name:___________________________ **First Name:**_________________ **Date of Birth**: _______________

Important: In order to provide the highest quality health care possible, it is important that we have the following information. Please answer all the questions as accurately as possible. If you do not understand a question, please ask for assistance. Thank you.

PREFERRED PHARMACY:_______________________ **PHONE:**____

Address:________________________________ City:_________________ State:_______ Zip:______________

PRIMARY CARE PHYSICIAN:________________________________ **PHONE:** _____________________________

Address:_______________________________ City:___________________ State:_______ Zip:______________

DO YOU SEE ANY OTHER PHYSICIANS?

PHYSICIAN:________________________________**SPECIALTY:**____

Phone:__________________________Address:____

PHYSICIAN:________________________________**SPECIALTY:**____

Phone:__________________________Address:____

ALLERGIES: (please note your reaction)____

LIST ALL MEDICATIONS: (Prescribed, Over-the-Counter, Herbal)

MEDICATION/DOSE/FREQUENCY	MEDICATION/DOSE/FREQUENCY

Last Name_____________________________**First Name**___________________**Date of Birth** ________________

GYN HISTORY:

Date of Last Period (first day):________________ Date of Last Mammogram:_____________________

Date of Last Colonoscopy:___________________ Date of Last Bone Density Screen:________________

Date of Last Pap Smear:________________ Have You Ever Had an Abnormal Pap Smear? Yes / No When? ________

Did You Receive the HPV Vaccine Series (3 injections)? Yes / No

Are You Sexually Active? Yes / No If Yes; Men Women Both

Have You Ever Been Diagnosed With a Sexually Transmitted Infection (STI)? Yes / No , Which One?_________________

Current Method of Birth Control:__________________________

How Often Do You Get Your Menstrual Cycle? Every __________ Days Menstrual Cycle Length:__________ Days

Pain With Cycle: Mild Moderate Heavy Bleeding: Mild Moderate Heavy

Age Your Period Began:________________ If Postmenopausal, Age at Menopause:________________

Have You Ever Been on Hormone Replacement Therapy? Yes / No Are You Currently on HRT? Yes / No

Please List Medication(s): ___________________________________

History of? Endometriosis Fibroids Infertility PCOS Ovarian Cysts Postmenopausal Bleeding

OBSTETRICAL HISTORY:

How Many Times Have You been pregnant? ____________

Number of Full-Term Deliveries? _______
Number of Pre-mature Deliveries? _______
Number of Miscarriages? _______
Number of Living Children? _______

Number of Abortions? _______
Number of Ectopics? _______
Number of Multiple-gestation Births? _______

PAST PREGNANCIES:

	Delivery Date	# of Fetus	Weight	Sex	Delivery Type (Vaginal/Cesarean)	Full-term or Pre-mature	Complications During Pregnancy or Delivery
1	/ /						
2	/ /						
3	/ /						
4	/ /						
5	/ /						
6	/ /						

Last Name____________________________**First Name**__________________**Date of Birth** ________________

PAST MEDICAL HISTORY: (Check those that apply, please add any necessary notes below)

Cancer	Breast Cervical Colon Uterine/Endometrial Ovarian Vaginal Vulvar Skin Lung Other ____________
Cardiology	Arrhythmia Heart Disease Murmur/Valve Prolapse Hypertension High Cholesterol Other __________
Dermatology	Acne Eczema/Psoriasis Other ____________
Ears/Nose/Throat	Hearing loss Allergies/Rhinitis Other ____________
Endocrinology	Diabetes Mellitus Insulin Resistance Gestational DM Hyperthyroidism Hypothyroidism Prolactinoma Vitamin Deficiency Other ____________
Eyes	Glaucoma Vision Loss Macular Degeneration Other ____________
Gastrointestinal	Colon Polyps Crohn's Disease Ulcerative Colitis Gallbladder Disease Hemorrhoids Irritable Bowel Syndrome Liver Disease/Hepatitis Other ____________
Hematology	Anemia Blooding Disorder Clotting Disorder Prior Transfusion DVT/PE Other ____________
Infectious Disease	Chicken Pox/Shingles HIV MRSA Tuberculosis Other ____________
Nephrology	Renal Disease Other ____________
Neurology	Dementia Headaches/Migraines Multiple Sclerosis Seizures Stroke/TIA Other ___________
Orthopedic	Back Pain Fractures Other ____________
Psychiatry	ADD/ADHD Anxiety Bipolar Disorder Depression Eating Disorder Other ____________
Pulmonology	Asthma COPD/Emphysema Sleep Apnea Other ____________
Rheumatology	Autoimmune Disease Fibromyalgia Other ____________
Urology	Blood in Urine Interstitial Cystitis Recurrent UTIs Stones Incontinence Other __________
Notes	

SURGICAL HISTORY: (Please list any surgeries you have had)

Procedure	Physician	Date

FAMILY HISTORY:

Mother: □ Living □ Deceased - Cause and Age at Death: ____________________________

Father: □ Living □ Deceased - Cause and Age at Death: ____________________________

Number of Siblings:______________ Living:______________ Deceased:______________ Cause:______________

Last Name____________________________**First Name**___________________**Date of Birth** ________________

Have any of Your blood relatives had the following? Please specify the age and relationship.

		Relative			Relative
Alzheimer's	Yes / No		High Blood Pressure	Yes / No	
Anemia	Yes / No		Kidney Disease	Yes / No	
Anxiety	Yes / No		Malignant Disease	Yes / No	
Asthma	Yes / No		Uterine Cancer	Yes / No	
Blood Disorder	Yes / No		Breast Cancer	Yes / No	
Stroke	Yes / No		Cervical Cancer	Yes / No	
Dementia	Yes / No		Colon Cancer	Yes / No	
Depression	Yes / No		Ovarian Cancer	Yes / No	
Diabetes Mellitus	Yes / No		Pancreatic Cancer	Yes / No	
Disorder of Nervous System	Yes / No		Mental Disorder	Yes / No	
Disorder of Thyroid	Yes / No		Heart Attack	Yes / No	
Heart Disease	Yes / No		Osteoporosis	Yes / No	
High Cholesterol	Yes / No		Substance Abuse	Yes / No	
Other					

SOCIAL HISTORY:

Marital Status: Single Married Divorced Separated Widowed Domestic Partner

Occupation:__________________________ Level of Education:__________________________

Exercise Level: None Occasional Moderate Heavy

Smoking Status: Never a Smoker Former Smoker Current Smoker

Pack(s) Per Day:__________ Have Been Smoking Since:___________Years Old

Alcohol Intake: None Occasional Moderate Heavy

Do You Use Illicit Drugs? Yes No If Yes, Which Ones? ____________________________

Have You Ever Been the Victim of Domestic Violence or Abuse? Yes No

Is a Blood Transfusion Acceptable in an Emergency? Yes No

Do You have an Advance Directive? Yes No

Have You Travelled to a Zika-Affected Area in the Last 12 Weeks? Yes No

Are You Experiencing, or Have You Recently Experienced, Fever, Rash, Joint Pain and Conjunctivitis? Yes No