PATIENT INTAKE HISTORY			
Patient Name:	Birth Date: / /	SSN: - -	Date: / /

Name you would like to use:
Why have you come to the office today? Is this a new problem:
Whom may we thank for referring you to our office:

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

KNOWN ALLERGIES	
Type (Medication or Other)	Reaction
1.	1.
2.	2.

IMMUNIZATIONS/ TEST			
	Date		Date
Tetanus-Diphtheria Booster		Influenza Vaccine (Flu Shot)	
Hepatitis A Vaccine		Hepatitis B Vaccine	
Varicella Vaccine		Pneumococcal Vaccine	
Measles-Mumps-Rubella (MMR) Vaccine		Tuberculosis (TB) Skin Test - Result:	
Shingles Vaccine		Human Papilloma Virus (HPV) Vaccine	

FAMILY HISTORY			
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)	□		
Hepatitis	□		
HIV/AIDS	□		
Tuberculosis	□		
Birth Defects	□		
Drinking or Drug Problems	□		
Breast Cancer	□		
Colon Cancer	□		
Ovarian Cancer	□		
Uterine Cancer	□		
Mental Illness/ Depression	□		
Alzheimer's Disease	□		
Other	□		

PERSONAL PAST HISTORY OF ILLNESSES				
Major Illnesses	Yes (Date)	No	Not Sure	Physician's Notes
Asthma				
Pneumonia/ Lung Disease				
Kidney Infections/ Stones				
Tuberculosis				

PATIENT INTAKE HISTORY			
Patient Name:	Birth Date: / /	SSN: - -	Date: / /

PERSONAL PAST HISTORY OF ILLNESSES (cont)				
Major Illnesses	Yes (Date)	No	Not Sure	Physician's Notes
Sexually Transmitted Disease				
HIV/ AIDS				
Heart Attack/Problems				
Diabetes				
High Blood Pressure				
Stroke				
Rheumatic Fever				
Blood Clots in Lungs or Legs				
Eating Disorders				
Collagen Vascular Disease (Lupus)				
Chickenpox				
Cancer				
Reflux/ Hiatal Hernia/ Ulcers				
Depression/ Anxiety				
Anemia				
Blood Transfusions				
Seizures/ Convulsions/ Epilepsy				
Bowel Problems				
Glaucoma				
Cataracts				
Arthritis/ Joint Pain/ Back Problems				
Broken Bones				
Hepatitis/ Yellow Jaundice/ Liver Disease				
Thyroid Disease				
Gallbladder Disease				
Headaches				
Other				

OPERATIONS/HOSPITALIZATIONS		
Reason	Date	Hospital

SOCIAL HISTORY					
Marital Status	□ Single	□ Married	□ Separated	□ Divorced	□ Widowed
Ethnicity	□ Caucasian	□ African American	□ Hispanic	□ Asian	□ Other _____

Occupation:	Yes	No	Physician Notes
Do you currently smoke? _____ Packs Per Day – For _____ Years	□	□	
Do you currently drink alcohol? _____ Drinks Per Day - _____ Times Per Week	□	□	
Recreational Drug Use	□	□	
Regular Exercise? How Long _____ How Often?	□	□	
Dairy Product Intake/ Calcium Supplements: Quantity	□	□	
Have You Been Sexually Abused, Threatened, or Hurt By Anyone?	□	□	

PATIENT INTAKE HISTORY

Patient Name:	Birth Date: / /	SSN: - -	Date: / /

GYNECOLOGIC HISTORY

	Physicians Notes
Last normal menstrual period (First Day): / /	
Age periods began:	
Length of periods (number of days bleeding):	
Number of days between periods:	
Any recent changes in periods?	
Are you currently sexually active? Have you ever had sex?	
Number of sexual partners (lifetime):	
Sexual partners are □ male □ female □ both	
Present method of birth control:	
Have you ever used an intrauterine device (IUD) or birth control pills?	
If yes, for how long?	
When was your last pap test?	
What was the result?	
Have you ever had an abnormal pap test?	
If yes, what was the treatment for the abnormal pap test? □ Colposcopy □ Cryotherapy □ LEEP □ Cold Knife Cone □ Other	
Do you do regular breast self-examinations?	
When was your last Mammogram: / /	
Where did you have your last Mammogram done?	
When was your last Bone Density Test: / /	
Where did you have the BDT done?	
When was your last Colonoscopy: / /	
Where did you have the Colonoscopy done?	

CURRENT MEDICATIONS

(Including hormones, vitamins, herbs, nonprescription medications)

Drug Name	Dosage	Who Prescribed	Drug Name	Dosage	Who Prescribed

PREFERRED PHARMACY

Name		Phone#	
Address			

OBSTETRIC HISTORY

	Number		Number		Number
Pregnancies		Abortions		Miscarriages	
Premature Birth (<37 weeks)		Live Births		Living children	

NO.	Birth Date	Weight at Birth	Baby's Sex	Weeks Pregnant	Type of Delivery (vaginal, cesarean)	Complications?
1.						
2.						
3.						
4.						

Physician's Notes on Obstetric History:

PATIENT INTAKE HISTORY

Patient Name:	Birth Date: / /	SSN: - -	Date: / /

REVIEW OF SYSTEMS

(Please indicate if any of the following symptoms apply to you now or since adulthood)

	Now	Past	Unsure		Now	Past	Unsure
1. Constitutional				Involuntary/Unintended Urine Loss	□	□	□
Weight Loss	□	□	□	Urine Loss when Coughing or Lifting	□	□	□
Weight Gain	□	□	□	Abnormal Bleeding	□	□	□
Fever	□	□	□	Painful Periods	□	□	□
Fatigue	□	□	□	Premenstrual Syndrome (PMS)	□	□	□
Change in Height	□	□	□	Painful Intercourse	□	□	□
2. Eyes				Fibroids	□	□	□
Double Vision	□	□	□	Infertility	□	□	□
Spots Before Eyes	□	□	□	DES Exposure	□	□	□
Vision Changes	□	□	□	Abnormal Vaginal Discharges	□	□	□
Glasses/ Contacts	□	□	□	**8. Musculoskeletal**			
3. Ear, Nose and Throat				Muscle Weakness	□	□	□
Earaches	□	□	□	Muscle or Joint Pain	□	□	□
Ringing in Ears	□	□	□	**9. Skin**			
Hearing Problems	□	□	□	Rash	□	□	□
Sinus Problems	□	□	□	Sores	□	□	□
Sore Throat	□	□	□	Dry Skin	□	□	□
Mouth Sores	□	□	□	Moles	□	□	□
Dental Problems	□	□	□	**10. Breasts**			
4. Cardiovascular				Pain in Breast	□	□	□
Painful Breathing	□	□	□	Nipple Discharge	□	□	□
Chest Pain or Pressure	□	□	□	Lumps	□	□	□
Difficulty Breathing on Exertion	□	□	□	**11. Neurologic**			
Swelling of Legs	□	□	□	Dizziness	□	□	□
Rapid or Irregular Heartbeat	□	□	□	Seizures	□	□	□
5. Respiratory				Numbness	□	□	□
Wheezing	□	□	□	Trouble Walking	□	□	□
Spitting up Blood	□	□	□	Severe Memory Problems	□	□	□
Shortness of Breath	□	□	□	Frequent or Severe Headaches	□	□	□
Chronic Cough	□	□	□	**12. Psychiatric**			
6. Gastrointestinal				Depression or Frequent Crying	□	□	□
Frequent Diarrhea	□	□	□	Severe Anxiety	□	□	□
Bloody Stool	□	□	□	**13. Endocrine**			
Nausea/Vomiting/Indigestion	□	□	□	Hair Loss	□	□	□
Constipation	□	□	□	Heat/ Cold Intolerance	□	□	□
Involuntary Loss of Gas or Stool	□	□	□	Abnormal Thirst	□	□	□
7. Genitourinary				Hot Flashes	□	□	□
Blood in Urine	□	□	□	**14. Hematologic/Lymphatic**			
Pain with Urination	□	□	□	Frequent Bruises	□	□	□
Strong Urgency to Urinate	□	□	□	Cuts Do Not Stop Bleeding	□	□	□
Frequent Urination	□	□	□	Enlarged Lymph Nodes (Glands)	□	□	□
Incomplete Emptying	□	□	□				

Patient Signature	Date