GYNECOLOGIC INTAKE HISTORY

NAME_____ **BIRTH DATE**___/___/___ **AGE**___ **DATE**___/___/___
RACE____ **HT**____**WT**____ **REASON FOR VISIT**_____
WERE YOUR REFERRED BY SOMEONE?_____**IF YES, WHO?**_____
DATE LAST MENSTRUAL PERIOD___/___/___ **LENGTH OF PERIOD**_____
DAYS BETWEEN PERIODS _____ **BIRTH CONTROL METHOD**_____
LAST PAP_____ **ABNORMAL PAP SMEAR OR MAMMOGRAMS**_____
NUMBER OF PREGNANCIES_____ **MISCARRIAGES**_____ **ABORTIONS**_____
ECTOPIC PREGNANCIES_____ **CESAREAN SECTIONS**_____**TERM BIRTHS**_____
LIVING CHILDREN_____

PLEASE CIRCLE ANY OF THE FOLLOWING YOU HAVE HAD AND NOTE THE YEAR:

VAGINAL DISCHARGE	_____	PAIN WITH SEX	_____	BLOOD DISORD.	_____
VAGINAL INFECTION	_____	D&C	_____	BLEEDING DISORD.	_____
PELVIC INFECTION	_____	DIARRHEA	_____	ANEMIA	_____
GONORRHEA	_____	CONSTIPATION	_____	HEPATITIS	_____
CHLAMYDIA	_____	BLACK STOOLS	_____	TUBERCULOSIS	_____
SYPHILIS	_____	BLOOD STOOLS	_____	GENITAL WARTS	_____
BREAST DISCHARGE	_____	PNEUMONIA	_____	ABNORMAL BLEED	_____
DES EXPOSURE	_____	BREAST LUMPS	_____	ASTHMA	_____
CONE BIOPSY/CRYO	_____	BREAST BIOPSY	_____	SHORTNESS BREATH	_____
FEMALE CANCER	_____	WEIGHT LOSS/GAIN	_____	OTHER LUNG DIS.	_____
OVARIAN CYSTS	_____	HIGH BLOOD PRESSURE	_____	BLOOD CLOTS	_____
OVARIAN TUMOR	_____	HOT FLASHES	_____	RHEUMATIC FEVER	_____
FIBROID TUMOR	_____	FEVER/CHILLS	_____	HEART MURMUR	_____
DYSPLASIA	_____	MIGRAINE/HEADACHES	_____	CHEST PAIN	_____
HERPES	_____	NAUSEA/VOMITING	_____	HEART DISEASE	_____
UNCTR URINATION	_____	THYROID	_____	STROKE	_____
PAINFUL URINATION	_____	DIABETES	_____	GALLBLADDER	_____
URINE FREQUENCY	_____	FAINTING SPELLS	_____	ULCERS	_____
KIDNEY STONE	_____	CANCER	_____	PAINFUL PERIODS	_____
KIDNEY INFEC.	_____	SWELLING	_____	CONVULSION	_____
OTHER	_____				

PLEASE CIRCLE YOUR ANSWER (YES OR NO) & FILL IN THE BLANKS

HAVE YOU EVER HAD PREVIOUS SURGERY? YES or NO IF YES, LIST SURGERY & YEAR
1)_____2)_____3)_____
4)_____5)_____6)_____

DO YOU HAVE ANY REGULAR MEDICAL PROBLEMS OR ILLNESSES? YES or NO IF YES, PLEASE LIST
1)_____2)_____3)_____
4)_____5)_____6)_____

DO YOU TAKE ANY REGULAR MEDICINES? YES or NO IF YES, PLEASE LIST_
1)_____2)_____3)_____
4)_____5)_____6)_____

SOCIAL HISTORY
DO YOU SMOKE? _____ PACKS PER DAY _____ YEARS_____
DRINK ALCOHOL? _____ DRINKS PER WEEK_____ DRUG USE_____
MARITAL STATUS_____ OCCUPATION _____

FAMILY HISTORY
PLEASE INDICATE ANY RELATIVE WITH THE FOLLOWING:
ANY WOMEN IN YOUR FAMILY HAVE/HAD CANCER? YES or NO IF YES PLEASE LIST
CANCER/ CERVIX_____CANCER/OVARY_____CANCER/BREAST_____CANCER UTERUS_____
OTHER CANCER_____HIGH BLOOD PRESSURE _____
HEART DISEASE_____

DATE REVIEWED:_____ **PHYSICIAN SIGNATURE:**_____
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