**Patient Intake Form**

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| --- |
| **Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_**  How did you hear about our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Reason for Visit (check): \_\_\_ Routine/Well Visit \_\_\_ Problem**  Any further issues you would like discussed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Gynecological Histor**y:

**First day of last period**: \_\_\_\_\_\_\_\_\_\_ (Or age of last period if postmenopausal/hysterectomy):\_\_\_\_\_\_\_\_\_\_\_\_

Age of first period: \_\_\_\_\_ # of days between periods: \_\_\_\_\_ # of days you bleed: \_\_\_\_\_\_

**Date of last pap smear**: \_\_\_\_\_\_\_\_\_\_\_ **What were the** **results** (circle): Normal Abnormal

Have you **Ever** had an abnormal pap in the past? (check): \_\_ Yes \_\_ No If yes, when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was any further treatment needed? (Colposcopy, LEEP/Cone, Cryotherapy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Most recent Mammogram**?\_\_\_\_\_\_\_\_\_\_\_\_ **Colonoscopy**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Bone Density**: \_\_\_\_\_\_\_\_\_\_\_

**Obstetrical History**:

Number of pregnancies \_\_\_\_\_\_

Live births \_\_\_\_ Vaginal Deliveries \_\_\_\_ Cesarean Sections \_\_\_\_ Miscarriages \_\_\_

Tubal Pregnancies \_\_\_\_ Terminations \_\_\_\_ Living Children \_\_\_\_\_

Current primary care physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently sexually active (check): \_\_ Yes \_\_ No \_\_ Never

Are there concerns about your sexual activity in which you would like to discuss today? \_\_ Yes \_\_ No

Current Contraception Method: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you completed the Gardasil Vaccine series (HPV vaccine)? \_\_ Yes \_\_ No \_\_ Incomplete

**Current Medications and/or supplements (with doses if known**): \_\_\_*No Current Meds*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list your preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication & food allergies (reactions if known**): \_\_\_*No known allergies*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Have you ever been diagnosed with/treated for any of the following (check):*** \_\_\_ ***None***

\_\_ HPV \_\_ Endometriosis \_\_ HIV

\_\_ Syphilis \_\_ Genital Herpes \_\_ PID

\_\_ Ovarian cysts \_\_ Trichomonas \_\_ Gonorrhea

\_\_ Genital warts \_\_ PCOS \_\_Fibroids

\_\_ Vaginitis \_\_ Chlamydia Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal & Family Medical History**: \_\_\_ *I have no knowledge of my family history*

\_\_ Ovarian Cancer/who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ Breast Cancer/who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Colon Cancer/who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_Heart Disease/who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Diabetes/who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ Osteoporosis/who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ **Endometrial Cancer**/who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ Thyroid Disease/who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other Symptoms**: \_\_\_ ***None***

\_\_ Vulvar itching/burning \_\_ Hair growth/ loss \_\_ Hot flashes

\_\_ Anxiety/ depression \_\_ Change in Urinary function \_\_ Breast discharge

\_\_ Pain w/intercourse \_\_ Diarrhea/ constipation \_\_ Headaches

***Any other medical conditions or additional information about the conditions marked:***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgeries & Hospitalizations: (approx. year)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:**

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you: \_\_ Married \_\_ Single \_\_ Engaged \_\_ Divorced \_\_ Widowed \_\_ Significant other

Do you exercise regularly: *Yes No* If yes/how often? \_\_\_\_\_\_\_\_\_

Smoke tobacco or Vape: *Yes No Past* If past when did you quiet? \_\_\_\_\_\_\_\_\_\_

Alcohol: Yes No If yes/how often? \_\_\_\_\_\_\_\_\_

Recreational drugs: Yes No If Yes/describe use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Todays Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*\*\*Note: if you would like to give anyone access to your account records or bills please fill out a records release form you can get from our front desk\*\*\***