

NORTHWEST PROFESSIONAL OBSTETRICS & GYNECOLOGY, LTD.

GYNECOLOGIC INTAKE AND HISTORY FORM

Today's Date: _____

Name: _____ Date of Birth: _____

Race: American Indian or Alaskan Native Asian Black or African-American
 More Than One Race Native Hawaiian Other Pacific Islander White
 Refused to Report/Unreported

Ethnicity: Hispanic or Latino Non-Hispanic or Latino Refused to Report/Unreported

Language: English Spanish Other _____

Preferred Local Pharmacy: _____
(Address/City)

Do you use a mail order pharmacy? _____ If so, please be sure we have your pharmacy provider information and a copy of your prescription drug card.

Preferred Mail Order Pharmacy: _____

Preferred Notification Method: Postal Mail Phone Web Message

Report any changes in your address, phone contact numbers, insurance, or emergency contact information to the front desk.

Reason(s) for coming to the doctor today:

	Reason 1	Reason 2
Reason for Today's Visit		
Timing/Onset: When did symptoms first occur?		
Duration: Frequency of symptoms.		
Characterized as/Severity: Describe the severity of the symptoms/pain.		
Associated Signs and Symptoms: Are there any other symptoms associated with your problem?		
Modifying Factors: What makes the condition better/worse?		
Has a previous provider provided treatment?	Name: Phone:	Name: Phone:

Menstrual and Gynecological History:

Date of last period: _____

Date of previous period: _____

Was your last period normal: Yes No

Are your periods regular: Yes No

Do you have spotting between: Yes No

Age at first period: _____

How many days from the first day of my period to the first day of my next period: _____

How long do your periods last: _____

Is your flow: Light Moderate Heavy

Are your periods painful: Yes No

If your periods are painful, please describe the pain: Mild Moderate Severe

Do you have other symptoms with your periods: Yes No

If yes, please list: _____

Have you ever had an abnormal pap smear: Yes No

If yes, please when: _____

If yes, what was the diagnosis: _____

If yes, how were you treated: _____

Have you ever been sexually active: Yes No

At what age did you become sexually active: _____

How many sexual partners have you had: _____

Are you currently sexually active: Yes No

Are you using contraception: Yes No

Do you have a history of infertility: Yes No

Do you have bleeding after intercourse: Yes No

Do you have pain with intercourse: Yes No

Do you leak urine: Yes No

Do you have chronic pelvic pain: Yes No

Pregnancy / Birth History:

How many times have you been pregnant? _____

How many abortions? _____

How many full term deliveries? _____

How many ectopic pregnancies? _____

How many pre-term deliveries? _____

How many living children? _____

How many miscarriages? _____

Date of Birth	Sex	Weight	Length of labor	Vaginal or Cesarean	Complications with pregnancy or delivery

Problem List/Past Medical History:

Have you been diagnosed with any of the following (currently or in the past)?

- | | | |
|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> GI Bleed | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> GERD | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Headaches, Chronic | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Colitis, Ulcerative | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Sleep Disorder |
| <input type="checkbox"/> Crohn's | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Deep Vein Thrombophlebitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tendinitis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Kidney Stone(s) | <input type="checkbox"/> Vascular Disease, Peripheral |

List any other important medical condition(s) you have had (do not include common colds or flu). Include date of initial diagnosis if possible:

Problem/Previous Diagnosis

Date(s) or Age

Past Surgical History:

List significant surgeries or injuries (continue on back if necessary):

Surgeries

Date(s) or Age

Medication History:

List any medications, vitamins, minerals, and herbs that you are currently taking or check the box below:

No Current Meds

Allergy History:

List known allergies (including medication allergies) or check one of the boxes below:

No Known Allergies (NKA)

No Known Drug Allergies (NKDA)

Social History:

Please describe your current tobacco use?

- Never Smoker Former Smoker Current every day smoker Current some day smoker
Current status unknown Unknown if ever smoked

Are you exposed to “second-hand” smoke? Yes No

If yes, please indicate by marking the appropriate boxes: Minimal Frequent Daily

Family members smoke indoors Family members smoke outdoors only

Please describe your current exercise routine: Inactive Light Moderate Vigorous

Do you drink beverages with caffeine? Yes No

If yes, please indicate what type of beverage and how many servings per day: _____

Have you ever used any illicit drugs? Yes No

If yes, please indicate what type of drug and how often: _____

Do you drink beverages with alcohol? Yes No

If yes, please indicate what type of beverage and how many servings per day: _____

What religion do you follow: _____

What is your most recent primary occupation? _____

Family History:

Has any member of your family been diagnosed with any of the following conditions (include deceased family members)?

	Father	Mother	Father’s Parents	Mother’s Parents	Siblings	Children
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Epilepsy/Convulsions	_____	_____	_____	_____	_____	_____
Bleeding Disorder	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Thyroid Disease	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____	_____	_____

List any other important family medical condition(s) you are aware of (do not include common colds or flu).
Include date of initial diagnosis if possible:

Family member

medical condition

Travel History:

List places you have traveled in the past two years—particularly to areas outside of the continental United States:

Please place a check mark in the box next to any of the following symptoms or problems if you have experienced them recently or have concerns about them. If you don't understand something place a question mark "?" by it. Your doctor will discuss any positive responses with you.

General:

- Chills
- Fever
- Fatigue
- Mood Swings
- Night Sweats
- Recent Unexpected Weight Change

Skin:

- Rash
- Itching
- Chronic Dry Skin
- Change in a Wart/Mole
- Wound Not Healing

HEENT:

- Blurred or Double Vision
- Eye Redness or Irritation
- Eye Discharge
- Decreased Vision
- Sensitivity to Light
- Earache
- Ringing in the Ears
- Decreased Hearing
- Nose Bleed(s)
- Decreased Sense of Smell
- Decreased Sense of Taste
- Nasal/Congestion or Pain
- Sore Throat

Neck:

- Neck Mass or Swelling
- Neck Pain
- Neck Stiffness

Respiratory:

- Shortness of Breath
- Snoring
- Chronic Wheezing
- Chronic Cough
- Coughing Up Blood

Breast:

- Breast Mass
- Breast Pain
- Breast Swelling
- Nipple Discharge
- Nipple Pain

Cardiovascular:

- Chest Pain
- Fainting/Blacking Out
- Shortness of Breath
- Swelling of Extremities

Gastrointestinal:

- Persistent Nausea/Vomiting
- Chronic Diarrhea
- Constipation
- Bloody or Very Black Stool
- Jaundice (Yellow Skin)
- Persistent Abdominal Pain

Female Genitourinary:

- Vaginal Discharge
- Vaginal Itching/Burning
- Uncontrolled Urination
- Painful Urination
- Blood in Urine
- Frequent Urination
- Pelvic Pain
- Painful Menstruation
- Urine Leakage

Musculoskeletal:

- Arthritis
- Back Pain
- Joint Pain
- Joint Swelling
- Joint Stiffness
- Muscle Weakness
- Muscle Aches and Pains

Neurological:

- Headaches
- Unable to Move Parts of Your Body at Times
- Difficulty Speaking
- Numbness/Tingling Sensations
- Seizures
- Tremors/Shaking Hands
- Fainting
- Dizziness/Vertigo

Psychiatric:

- Depression
- Memory Loss
- Impaired Cognitive Function
- Change in Sleep Pattern
- Panic Attacks
- Suicidal Thoughts

Endocrine/Glands:

- Appetite Changes
- Cold Intolerance
- Excessive Thirst
- Sexual Dysfunction

Hematology:

- Abnormal Bleeding
- Anemia
- Easy Bruising
- Painful Lymph Nodes