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 full term deliveries? ________________

How many pre-term deliveries? ________________

How many miscarriages? ______________________

How many abortions? ________________________

How many ectopic pregnancies? _______________

How many living children? ____________________

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)?

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

____

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____

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:

____

____

____

____

____

REVIEW OF SYSTEMS

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