

CARING FOR WOMEN, P.C.
GYNECOLOGIC INTAKE HISTORY

Name: _____ Birthdate: _____ Date: _____
 Established Patient New Patient Consult: Y N Referred by _____

REVIEW OF SYSTEMS

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST OR OFTEN			
	Currently	Past	COMMENTS
1. Constitutional			
Weight loss	_____	_____	
Weight gain	_____	_____	
Fever	_____	_____	
Fatigue	_____	_____	
2. Eyes			
Double vision	_____	_____	
Spots before eyes	_____	_____	
Vision changes	_____	_____	
3. ENT/Mouth			
Ear aches	_____	_____	
Ringing in ears	_____	_____	
Sinus problems	_____	_____	
Sore throat	_____	_____	
Mouth sores	_____	_____	
Dental problems	_____	_____	
4. Cardiovascular			
Painful breathing	_____	_____	
Chest pain	_____	_____	
Difficult breathing on exertion	_____	_____	
Swelling of legs	_____	_____	
Palpitations of heart	_____	_____	
5. Respiratory			
Wheezing	_____	_____	
Spitting up blood	_____	_____	
Shortness of breath	_____	_____	
Cough, chronic	_____	_____	
6. Gastrointestinal			
Diarrhea, frequent	_____	_____	
Bloody stool	_____	_____	
Nausea/vomiting	_____	_____	
Constipation	_____	_____	
7. Genitourinary			
Blood in urine	_____	_____	Age periods started _____ Duration of periods _____ days Periods – Heavy _____ Moderate _____ Light _____ Cramps for _____ days Cramps – mild _____ Moderate _____ Severe _____
Pain with urination	_____	_____	
Urgency	_____	_____	
Frequency of urination	_____	_____	
Incomplete emptying	_____	_____	
Stress incontinance	_____	_____	
Abnormal periods	_____	_____	
Painful intercourse	_____	_____	
8. Musculoskeletal			
Muscle weakness	_____	_____	
9. Skin/breast			
Pain in breast	_____	_____	
Discharge	_____	_____	
Masses	_____	_____	
Rash	_____	_____	
Ulcers	_____	_____	
10. Neurological			
Dizziness	_____	_____	
Seizures	_____	_____	
Numbness	_____	_____	
Trouble walking	_____	_____	
11. Psychiatric			
Depression	_____	_____	
Crying, frequent	_____	_____	
12. Endocrine			
Dry skin	_____	_____	
Abnormal thirst	_____	_____	
Hot flashes	_____	_____	
13. Hematologic/lymphatic			
Bruises, frequent	_____	_____	
Cuts do not stop bleeding	_____	_____	
Enlarged lymph nodes	_____	_____	
14. Allergic/Immunologic			
Allergies	_____	_____	
Drugs, other	_____	_____	

PERSONAL PAST HISTORY

MAJOR ILLNESS	YES	NO	MAJOR ILLNESS	YES	NO
Asthma			Cancer		
Pneumonia			Ulcers		
Chronic Lung disease			Depression/anxiety		
Kidney Infections / stones			Anemia / blood transfusions		
Tuberculosis			Seizures /convulsions / epilepsy		
Venereal Disease			Bowel Trouble		
Heart Trouble / Murmur			Glaucoma		
Diabetes			Arthritis / Joint Pain		
High Blood Pressure			Fracture		
Stroke			Hepatitis / yellow jaundice		
Rheumatic Fever			Thyroid Disease		

FAMILY HISTORY

ILLNESS	YES	RELATIVE
Diabetes		
Stroke		
Heart Disease		
High Blood Pressure		
Drinking Problem		
Breast Cancer		
Colon cancer		
Ovarian Cancer		

Mother - Living ___ Deceased ___ Cause _____
 Father - Living ___ Deceased ___ Cause _____
 Siblings: # living ___ # Deceased ___ Cause _____

OPERATIONS / HOSPITALIZATIONS

Reason	Date	Reason	Date

INJURIES / ILLNESSES

Type	Date	Type	Date

LAST IMMUNIZATION OR TEST

Tetanus	Date	Pneumonia	Date
Flu Shot	Date	TB Skin Test	Date

OB / GYN HISTORY

Births	Number	Abortions	Number
Miscarriages	Number	Living Children	Number

CURRENT MEDICATIONS

Drug Name	Dosage	Drug Name	Dosage

SOCIAL HISTORY

HABITS

Smoking Yes ___ No ___ Packs Per Day _____ Years _____
 Alcohol Yes ___ No ___ Drinks Per Day _____ Drinks Per Week _____
 Drug Use Yes ___ No ___
 Seat belt Use Yes ___ No ___ Are you or is anyone in your home, being hit or abused? _____
 Regular Exercise Yes ___ No ___

PERSONAL PROFILE

Marital Status Married ___ Single ___ Widowed ___ Divorced ___
 Number of Living Children _____
 Number of people in household _____
 School Completed High School ___ College ___ Graduate Degree ___ Other ___
 Current or Most Recent Job _____

I have had Herpes Y N Completed by: Patient ___ Office Nurse ___ Physician ___
 Venereal Warts Y N
 Chlamydia Y N Signature of Patient _____
 Gonorrhea Y N Date reviewed by physician with patient: _____

Physician Signature: _____

Subsequent Review of History

Date Reviewed: _____ Physician Signature: _____

Date Reviewed: _____ Physician Signature: _____

Date Reviewed: _____ Physician Signature: _____