New Gynecology Patient Intake Form

Texas Health Care – Obstetrics and Gynecology

Name: __________________________ DOB:____________ Primary Care Physician:_________________

Occupation:____________________ Education Level:_________________Employer:________________

Preferred pharmacy:_______________________________Pharmacy phone:________________________

Reason for Visit today:____

GYN History

First day of last period:___________
Age at your first period:________
Age of Menopause (if applicable): __________

How OFTEN are your periods (from 1st day to 1st day): Every _____ days.
How long are your periods (how many days of flow): ____ days
Do you have any concerns regarding your cycles?____

OB History:

of pregnancies:_____ # of living children:____ # of miscarriages:____ # of abortions/ectopic____

Delivery History:

Date	Male/Female	Term or Preterm (how many weeks?)	Baby's weight	Vaginal or C/Section	Anesthesia (epidural/spinal/none)	Complications (if any)

Medical History: Do you have now, or have you had ever….

High blood pressure	Asthma/COPD	Diabetes	UTIs	Blood clots (DVT/PE)
Osteopenia/porosis	Heart disease	Tuberculosis	Hepatitis	STD (sex transmitted infection)
Hearing/vision problem	Stroke (CVA)	GI problems	Migranes	Arthritis (OA/RA)
Thyroid problems	Anemia	Kidney problems	Seizures	Abnormal PAP smear
Gallbladder problems	Anxiety	Depression	Infertility	Other: ____________________

Medications:

Please list your medications below, including any herbal supplement, vitamins, or over the counter meds

Medication:	Dosage:	Directions
_______________________	__________________	____
_______________________	__________________	____
_______________________	__________________	____
_______________________	__________________	____
_______________________	__________________	____

Allergies:

Please list any MEDICATION ALLERGIES or food allergies with their reaction:

____

____

Surgical History:

Date	Procedure	Reason	Complications if any

Family History: Please indicate what family members if you check a box:

		Who?
	Breast Cancer	
	Colon Cancer	
	Ovarian Cancer	
	Cervical Cancer	
	Uterine Cancer	
	Other Cancer:	
	Stroke or TIAs	
	Thyroid problems	

		Who?
	Diabetes	
	High Blood Pressure	
	Heart Disease	
	Blood Clots (DVT/PE)	
	High Cholesterol	
	Osteoporosis	
	Kidney disease	
	Other:	

Social History: Please indicate if you use now, or have used in the past any of the following:

	Tobacco	Alcohol	Caffeine	Street drugs
Currently use				
Past use				
For how long				
What type				
How much	_____ packs/day	____drinks/week	____drinks/day	_____times/week

Are you sexually active, or have you ever had sex?_____

- With men/women/both?_________
- # of sexual partners in your lifetime: ________
- Do you have any concerns regarding sex to discuss today?________________________________

Diet type (regular, vegetarian, etc):______________________________

Do you exercise?______ What type and how often?____

SAFETY

Do you live in a safe environment?_______

Do you need help today?____

Screening history: when was your last….

	Year	Result (was it normal?)
Pap smear		
Mammogram		
Colonoscopy		
Bone Density Scan		

Family Planning:

What do you use for birth control (please indicate if vasectomy/tubal also):_________________

Do you want something different?__________________

Review of Systems: Please mark any of the following symptoms you have

Constitutional

	chills
	fatigue
	fever
	mailise
	night sweats
	weight gain
	weight loss

Head/eye/ear/nose

	Ear drainage
	ear pain
	eye discharge
	eye pain
	hearing loss
	nasal drainage
	sinus pressure
	sore throat
	visual changes

Respiratory

	chronic cough
	new cough
	TB exposure
	shotness of breath
	wheezing

Cardiac

	chest pain
	claudicaiton (leg pain)
	swelling
	palpitations

Gastrointestinal

	abdominal pain
	blood in stool
	change in stool
	constipation
	diarrhea
	heartburn
	loss of appetite
	nausea
	vomiting

Urinary

	pain with urination
	blood in urine
	urinating frequently
	leaking urine
	unable to urniate

Gyn/Reproductive

	abnormal pap
	pain with periods
	pain with sex
	hot flashes
	irregular menses
	vaginal discharge
	heavy periods

Skin/Breast

	nipple discharge
	breast lump
	brittle hair
	brittle nails
	hair loss
	hirsuitism
	hives
	itching
	mole changes
	rash
	skin lesion

Neurologic

	dizziness
	numbness
	weakness
	gait distrubance
	headache
	memory loss
	seizures
	tremors

Pyschiatric

	anxiety
	depression
	insomnia

Metabolic/Endocrine

	cold intolerance
	heat intolerance
	driking more fluid
	eating more food

Musculosketal

	back pain
	joint pain
	joing swelling
	weakness
	Neck pain

Hematology

	easy bleeding
	easy bruising
	swollen lymph nodes

Allergies

	contact allergies
	environmental allergies
	food allergies
	seasonal allergies

Please Mark here if you have none of the above symptoms