ALL CHILDREN'S OB/GYN SPECIALISTS
NEW PATIENT INTAKE FORM

Name _____ Age ____ DOB ___/___/___ Date ___/___/___

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, leave it blank. You can discuss them with your health care provider. If you cannot remember specific details, please provide your best guess. Thank you!

Main reason for today's visit: _____
Please describe other concerns you may have: _____
_____
Pharmacy _____Address _____ Phone # _____

GYNECOLOGIC HISTORY

What age did you begin having periods? _____
What is the first day of your last menstrual period? __/__/__
What is your usual length of flow?_____
How many days apart are your menstrual cycles starting from the first day of one cycle to the first day of your next cycle?_____
Any recent change in your menstrual periods? □ Yes □ No
If you are menopausal, what age did your periods stop? _____

When was your last pap smear? ___/___/___ Result? □ Normal □Abnormal
Have you ever had an abnormal pap result? □ Yes □ No
Treatment? _____
Did your mother take the drug Diethylstilbestrol (DES) when she was pregnant with you?
□ Yes □ No Last Mammogram___/___/___ Colonoscopy___/___/___ Dexa___/___/___

Are you currently sexually active? □ Yes □ No
Have you ever had vaginal intercourse? □ Yes □ No
At what age did you become sexually active? _____
Sexual partners are □ Male □ Female □ Both
How many sexual partners have you had in your life? _____
What do you currently use to prevent pregnancy? _____
Past birth control methods used:
□ Condoms □ Birth control pills □ Withdrawal □ Tubal Ligation □ Diaphragm
□ Patch □ Rhythm □ Vasectomy □ Vaginal Film □ Vaginal Ring □ IUD □ Essure

Have you ever been treated for: □ Herpes □ Chlamydia □ Gonorrhea □ Syphilis
□ Trichomonas □ Pelvic Inflammatory Disease □ Genital Warts and/or HPV
□ Bacterial Vaginitis □ Trichomoniasis
Have you ever tested positive for HIV (human immunodeficiency virus)? □ yes □ no
Do you want to be screened for sexually transmitted infections today? □ yes □ no
We routinely screen all women less than 26 years of age per ACOG guidelines. Be sure to tell your doctor or midwife if you do not want to be screened.

Pregnancy History

_____Check here if you have never been pregnant
_____Check here if you have adopted children and list names and ages below:
_____

Please list all pregnancies in order, including miscarriages, premature births, stillbirths, ectopics (tubal), and abortions:

Year	M/F	Weeks Pregnant	Type of Delivery (vaginal, C/S, forceps)	Complications (preterm labor, diabetes, toxemia, other)	Name/Age

Personal Medical History

Please indicate whether you have had any of the following medical problems (with dates):

_____Diabetes
_____Cancer
_____High Blood Pressure/Stroke
_____Asthma
_____Heart Disease
_____Blood Clots
_____Heart Attack
_____Mitral Valve Prolapse
_____Kidney/bladder infections/stones
_____Peptic/Gastric Ulcer Disease
_____Epilepsy/Seizures
_____Gallbladder problems
_____Liver Disease/Hepatitis/Cirrhosis
_____Blood Disorders/Sickle Cell Disease
_____Poor Circulation/Peripheral Vascular disease
_____Thyroid problems
_____Breast Disease/Breast Cancer
_____Blood in stools
_____Depression
_____Migraines
_____Glaucoma
_____Rheumatic Fever
_____Tuberculosis
_____Leaking of urine
_____COPD/Emphysema
_____Skin/Dermatologic Disorders
_____Osteoporosis/Bone Loss
_____Bone Fractures
_____PMS / PMDD

Surgery/Hospitalization

Date	Reason ☐ None

Family History

Please indicate family members (parent, sibling, grandparent, aunt, uncle or child) with any of the following conditions:

Alcoholism_____	Diabetes _____
Colon Cancer _____	Blood clots in lungs or legs _____
Breast Cancer _____	Birth defects _____
Uterine Cancer _____	Osteoporosis _____
Ovarian Cancer _____	Thyroid Disease_____
Heart Disease _____	High blood pressure_____
Depression/suicide _____	Stroke_____
Asthma/COPD_____	High Cholesterol _____
Genetic disorders _____	Hepatitis _____
Kidney Disease_____	Allergies/Asthma_____
Mental Illness_____	Other _____

Immunization History

Please indicate whether you received the following immunizations and the dates

Pneumovax_____		Hepatitis B _____
Influenza (flu shot) _____		Hepatitis A _____
HPV Gardisil series_____		MMR _____
Chicken Pox (illness) or shot_____		Meningitis _____
Tdap(tetanus & pertussis)_____	Tetanus (Td)_____	Shingles _____

Social History

Tobacco Use

Cigarettes □ Never □ Quit Date _____

□ Current smoker: packs/day _____ # of years_____

Other tobacco _____

Is your house a smoke-free house? □ Yes □ No

Are you interested in quitting? □ Yes □ No

Alcohol Use

Do you drink alcohol? □ Yes □ No

If yes, number of drinks per week? _____

Is your alcohol a concern for you or others? □ Yes □ No

Drug Use

Do you any recreational drugs? □ Yes □ No

Have you ever used needles to inject drugs? □ Yes □ No

Socioeconomics

Occupation_____Employer_____

Years of education/highest degree: _____

Marital Status □ Single □ Partner/Married □ Divorced □ Widowed □ Other

Spouse/partner's name _____

Number of children/ages: _____

Who lives at home with you? _____

Diet, Exercise & Habits

Caffeine Intake: □ None □ Coffee/tea/soda _____ cups/day
Weight : Are you satisfied with your weight? □ Yes □ No
Diet: How do you rate your diet? □ Good □ Fair □ Poor
Do you eat or drink four servings of dairy or take calcium supplements? □ Yes □ No
Exercise: Do you exercise regularly? □ Yes □ No
What kind of exercise? _____
How long (minutes) _____ How often? _____
If you do not exercise, why? _____
Safety: Do you use a bike helmet? □ Yes □ No
Do you use seatbelts consistently? □ Yes □ No
Is violence at home a concern for you? □ Yes □ No
Has anyone ever hurt you, hit you, or abused you physically or emotionally? □ Yes □ No
Have you ever been sexually abused? □ Yes □ No
Are you currently in a safe environment? □ Yes □ No

Current Medications

(including hormones, vitamins, herbs, nonprescription medications)

Drug Name	Dosage	Date started	Drug Name	Dosage	Date started

Review of Systems

Please check any current symptoms you have.

Constitutional: □ Fevers/chills/excessive sweating □ Unexplained weight loss/gain/fatigue
Gastrointestinal: □ abdominal pain □ nausea/vomiting/diarrhea □ constipation □ blood in stools
Eyes/ears/nose/throat: □ vision changes □ hearing loss □ mouth breathing/snoring
□ difficulty hearing/ringing in ears □ hayfever/allergies/congestion
Genitourinary: □ concern with sexual function □vaginal discharge □painful or bloody urination
□ leaking urine
Cardiovascular: □shortness of breath □palpitations
Skin: □rashes □ new or change in mole □ acne
Psychiatric: □Anxiety/depression □insomnia/nightmares □bad temper/angry outbursts
Blood/Lymph: □unexplained lumps □ easy bruising/bleeding
Respiratory: □cough / wheeze
Neurological: □ headaches □ fainting □ memory loss
Musculoskeletal: □ muscle/joint pain or edema □ Recent back pain
Breast: □ lumps or masses □ nipple discharge □ painful breasts

Allergies

Please list any allergies or reactions to medications: □ None

Medications	Reaction